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VOLUME 2

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NUMBER 4

EDITORIAL

THE ROLE OF THE PHYSICIAN IN THE EARLY DETECTION OF CANCER OF THE BLADDER

HUGH J. JEWETT, M.D.*

Cancer of the urinary bladder is sufficiently prevalent, disabling, and lethal to warrant a concerted effort to recognize it in its earliest stages. A survey conducted by the Federal Security Agency of the U. S. Public Health Service disclosed the death rate from this disease per 100,000 population during 1945 to be 10.5 among individuals 55 to 64 years of age, 26.2 among individuals 65 to 74, and 49.4 among individuals 75 to 84. The ratio of males to females was 2:1.

Etiological mechanisms now under suspicion are for the most part purely conjectural. The identification of the specific carcinogenic activity of B-naphthylamine, a compound used in the chemical industry, has stimulated speculation concerning possible causes of non-occupational bladder tumors in the general population, but proof of carcinogenicity for the bladder of other compounds has been lacking in clinical practice. Some tumors very probably result from persistent irritation of the vesical mucosa.

The tumor may commence either as a minute projection of epithelium surrounding a core of connective tissue containing a blood vessel, or as a focus of anaplasia within the vesical mucosa itself. In either event malignant cells finally break through the underlying basement membrane and invade the bladder wall and its lymphatics and blood vessels. Metastases to retroperitoneal lymph nodes, liver, lungs, and bones are common when the tumor has infiltrated deeply into the muscle layer of the bladder, and the prospect for cure by surgery diminishes as the extent of infiltration increases.

The rapidity with which a carcinoma can infiltrate the wall of the bladder bears some relation to the degree of anaplasia of its cells. Undifferentiated tumors may extend through the wall in a few weeks, whereas well differentiated tumors may require several months. *Recognition of a tumor within a short time after the onset of symptoms therefore becomes a matter of considerable importance to the patient.*

The cardinal symptoms are hematuria and frequency of urination. In a group of 73 cases of cancer of the bladder in which complete study had excluded other urological disease as a possible cause of the symptoms, 65 patients had complained of blood in the urine. In 7 of these the hematuria was at the end of urination, and in 2, at the beginning.

* Editorial Board, Maryland State Medical Journal.

In 6 additional cases erythrocytes were found only by microscopic examination, so that 71 of these 73 patients had hematuria of varying degree. Fifty-five of the 73 patients complained of frequency, but the urine was reported to contain bacteria in only 17.

As a rule a patient complaining of hematuria with or without frequency consults his family physician first. Since blood in the urine is known to occur in many conditions other than cancer, the temptation to temporize may be strong. However, *bleeding usually is the earliest and most characteristic symptom* of malignant disease of the urinary tract, and even if transient or painless its degree is no reliable guide to the gravity of the situation.

At present, exfoliative cytology (stained smears of the urinary sediment) and biologic tests for malignancy are of no practical value to the physician in the early detection of cancer of the bladder. But his insistence upon immediate and definitive investigation makes possible an early diagnosis in a high percentage of cases. When the tumor is found to be small and superficially infiltrating, surgical removal provides a 5-year survival rate of 83 per cent. When symptoms occur late or are neglected, tumor cells generally have had time to reach the deeper layers of the bladder, and the 5-year survival rate even after total cystectomy is only 10 per cent.

UNITED STATES MEDICAL AND DENTAL ACADEMY

THE AMA WASHINGTON LETTER NO. 7, FEBRUARY 13, 1953

H. R. 2718 (Heller, D., N. Y., Feb. 6). Would create a medical and dental school for physicians and dentists of the armed services and the Public Health Service. Four students would be selected from each Congressional district and each territory, six from the District of Columbia, four from Puerto Rico, two from the Canal Zone, eight from each State, and one-hundred thirty-two from the United States at large. Each Senator and Representative would be entitled to have four of his appointees in the school at all times. Course of study would be such as prescribed in "responsible and recognized medical and dental schools." (A similar bill by the same author last Congress provided that the course of study be prescribed by the American Medical Association and listed subjects to be included.) Upon graduation students would be commissioned in the armed services or the Public Health Service as needed and could be required to stay in such service for at least 5 years. In direct charge of the Academy would be a Superintendent to be appointed by the President with the consent of the Senate. Matters of policy, including the number of instructors and courses of study, would be decided by the Secretary of Defense and the Surgeon General of the Public Health Service, upon recommendations by the Superintendent. A Board of Visitors would include 5 persons appointed by the President, 3 of whom at least shall be outstanding in the fields of medicine or medical research. *To Interstate and Foreign Commerce Committee.*

HONORING "OUR GUS"

After a long and "faithful" service to the medical profession in Maryland, it seemed most appropriate that recognition was taken of a valued employee, Gustave Orville Caution.

At the meeting of the Baltimore City Medical Society, Friday, February 20, 1953, the Medical and Chirurgical Faculty and the Baltimore City Medical Society presented Gus with appropriate resolutions and monetary gifts. The State Board of Medical Examiners previously had given him a humidor, pipe rack and pipe.

The Editor of the Journal believes that the ceremony honoring Gus is of interest to all the members of the Medical and Chirurgical Faculty and therefore the following is published in detail:

DR. WETHERBEE FORT:¹ Dr. Chatard and Dr. Kloman, will you please come up to the platform?

The next order of business is a very pleasant one. We are going to honor a member of our cast who has been performing in a magnificent way for us all for many many years.

February twentieth, fifty-six years ago, a slip of a lad, Gustave O. Caution—better known to us as "Gus"—was employed temporarily by the late Miss Marcia C. Noyes, Librarian and Executive Secretary. To the best of anyone's knowledge he has never actually been formally employed by either the Medical and Chirurgical Faculty or the Baltimore City Medical Society. He has just stayed on and we put up with him.

So tonight both organizations felt that it would be only right and proper for each to present "Gus" with a little present and a testimonial.

Walter, will you please bring "Gus" to the platform?

(IS ESCORTED TO THE PLATFORM WHILE AUDIENCE APPLAUDS)

DR. FORT: I will ask Dr. Chatard to make the first presentation.

DR. J. ALBERT CHATARD:² It seems to me that only a few years ago I did very much the same thing for Miss Noyes.

¹ President, Baltimore City Medical Society.

² Treasurer, Medical and Chirurgical Faculty.

"Gus" has been with us fifty-six years. He has been with us long and knows us all well. I want to say a few words to him before I read a resolution; that he is right in the midst of his friends. Some of them may be very young; some of them may be middle age; some of them may be quite old; others may be absent in the City or State. They are still his friends, and particularly on the walls, "Gus" there are a lot of your friends.



GUS WALTER

Gus being escorted to the platform by his son, Walter Caution

Now I just want to say these few words because I have known "Gus" for fifty years. Over half a century has gone by but the fifty-six years have changed your activity very little. You still have the small, dapper figure you have always had; the smile is there at all times. The hair a little thinner and both it and the mustache a little grayer, but your activity a marvel to all of us as we hear the "feet patter" about as before.

Your great-great-grandfather, Samuel Caution

must have come to this Country as a French citizen about the same time my great-grandfather Pierre Chatard came here also, hence, I can understand your courteous, gentlemanly French manner which you have never lost.

The words in our resolution are helpful as a reminder to you of our thoughts. Within our hearts there is more the feeling that you are not in the class of the forgotten man.

Personally, I want to thank you, "Gus," for all the years you have been so thoughtful of me.

times and efficiency in dealing with the many problems presented, and

WHEREAS, his personal knowledge of so many of the very old and younger members and his recognition of them "in the dark," helped them with their sick calls during the meetings, therefore, be it

RESOLVED, that our members record their appreciation of this service by "one small man" for so "many," always with his smile as he patted about the various duties assigned to him, and be it further

RESOLVED, that a copy of this Resolution be spread on the Minutes of the next meeting of the Council of the Medical and Chirurgical Faculty, and be it further

RESOLVED, that a copy of this Resolution with the honorarium be given to Gustave Orville Caution as evidence of



DR. FORT

DR. KLOMAN

GUS

DR. CHATARD

Gus registers joy and gratitude upon receiving the gifts and resolutions

Your smile I cannot forget and your gentlemanly manner illustrates so well the old saying "Manners maketh the man." All best wishes, "Gus," for many, many more years with your family and friends both in and out of the Medical Profession.

Now I will read the resolution. This comes from the Medical and Chirurgical Faculty. There will be resolutions from the City Society as well as the State Board of Medical Examiners:

WHEREAS, Gustave Orville Caution has been a faithful and diligent employee of the Medical and Chirurgical Faculty of the State of Maryland for the past fifty-six years, and

WHEREAS, during that continuous duty at all the functions of the State Society, he has shown remarkable activity at all

our sentiment and regards, with all best wishes for many more years of a happy life.

MAURICE C. PINCOFFS, M.D., *President*

GEORGE H. YEAGER, M.D., *Secretary*

J. ALBERT CHATARD, M.D., *Treasurer*

C. R. EDWARDS, M.D., *Chairman of the Council*

(PRESENTATION TO "GUS" AND TREMENDOUS APPLAUSE)

DR. FORT: Thank you, Dr. Chatard. Now I will ask Dr. Kroman, President of the State Board of Medical Examiners, to read his resolution.

DR. E. H. KLOMAN: We of the Board, want to say everything that Dr. Chatard said to you, and I won't take the time in repeating it.

I want to read this resolution—but we were afraid we wouldn't be here tonight so we gave "Gus," two or three days ahead of time, the little token referred to in the resolution.

WHEREAS, Gustave Orville Caution has been a faithful, diligent employee of the Medical and Chirurgical Faculty of the State of Maryland for the past fifty-six years and

WHEREAS, during that long period he has been a ready, willing, cheerful, assistant to the Board of Medical Examiners, not only during the examination sessions, but whenever his

(APPLAUSE)

DR. FORT: I don't know whether you understood fully what Dr. Kloman said about what the Board gave Gus. It was an appropriately engraved humidor, pipe rack and pipe.

My remarks may not be as eloquent or the choice of words as grand as Dr. Chatard's, however, they will be right from the heart and just as sincere. There is one thing that is certain,



DR. KLOMAN DR. CHATARD GUS DR. FORT

Gus expresses to the members his thanks and appreciation of the honor given him

services have been requested. He has been, indeed, a "Minute Man" in his promptness and efficiency in performing the tasks assigned him, and has earned the affectionate good will of all the members of the Board by his deep loyalty to them and to the Board, therefore, be it

RESOLVED, that this Board record its appreciation of the friendly interested service of our friend "Gus," and our high personal regard for this kind, courteous gentleman, and be it further

RESOLVED, that a copy of this resolution be given to Gustave Orville Caution and that the Board of Medical Examiners of Maryland present him with this Humidor as a token of our sentiments and regard.

ERASMUS H. KLOMAN, M.D.
LEWIS P. GUNDRY, M.D.
SAMUEL McLANAHAN, M.D.
JOHN E. LEGGE, M.D.
HENRY T. COLLEBERG, M.D.
E. PAUL KNOTTS, M.D.
EDWARD P. THOMAS, M.D.
JOHN H. HORNBAKER, M.D.

I can top Dr. Chatard in one detail. I have known you two years longer than Dr. Chatard. This is not difficult to figure despite the difference in our ages—not yours but Dr. Chatard's and mine, because my father who was an ardent reader and a member of this Society used to bring me as a kid six or seven years of age to the old library building when he wanted you—to take care of me while he was reading. And if I remember—my figures bear me out—that takes us back to 1903, which is about fifty-two years ago.

So, with the reading of this resolution, "Gus," I want to present you also with a little token of our esteem.

WHEREAS, Gustave Orville Caution has been associated with the Baltimore City Medical Society for fifty-six years,

having entered the employment of the Medical and Chiurgical Faculty on February 20, 1897, and

WHEREAS, Gustave Orville Caution has, during that long period, served the Baltimore City Medical Society with distinction, and

WHEREAS, by his efficiency, loyalty, industry and unfailing courtesy, and by virtues which characterize him as a true gentleman, has endeared himself to the members of the Baltimore City Medical Society.

NOW, THEREFORE, BE IT RESOLVED, that the Baltimore City Medical Society at a meeting held on February 20, 1953, extend its hearty congratulations to Gustave Orville Caution with sincere good wishes for many more years of usefulness and happiness, and

BE IT FURTHER RESOLVED, that the Baltimore City Medical Society present to Gustave Orville Caution a token of its appreciation of his fifty-six years of faithful services, and

BE IT FURTHER RESOLVED, that this Resolution be spread upon the Minutes of the Baltimore City Medical Society and a copy thereof presented to Gustave Orville Caution.

WETHERBEE FORT, M.D., *President*

LEWIS P. GUNDRY, M.D., *Vice-President*

EDWARD F. COTTER, M.D., *Secretary*

ROBERT C. KIMBERLY, M.D., *Treasurer*

(PRESENTATION AND APPLAUSE)

GUSTAVE ORVILLE CAUTION: I want to thank Dr. Fort, Dr. Chatard, and Dr. Kloman and all the rest of the Faculty members for their courtesy toward me, and I appreciate the things that they have done for me at present and in the past.

I have tried to be faithful to you gentlemen ever since I came with the Faculty, as Sir William Osler who is dead now told me when I came to the Faculty, to be faithful to the Faculty and they would be faithful to me. I appreciate you gentlemen one and all for your faithfulness and I tried to do my service and will continue to do so if the Lord spares me. Thank you.

(AUDIENCE APPLAUDS IN OVATION)

DR. FORT: I would say that "Gus" is a very good speechmaker.

The Baltimore Evening Sun, on Friday, February 20, 1953, published an article on Gus together with his picture.

When Gus was with the Medical and Chiurgical Faculty fifty years, the Association had a brief ceremony during its Annual Meeting and gave him a substantial check.

On behalf of the entire Medical and Chiurgical Faculty, we wish to thank Gus for his services to the profession, during these many years, and hope he will continue to carry on his duties in his inimitable way and to be in the cloakroom, taking care of the hats and coats of the members, for many years to come.

HAVE YOU PAID YOUR A.M.A. DUES?

If not—and you wish to attend the meeting, mail your check to the Faculty Building but make it payable to the American Medical Association.

For the first time in many years, the Annual Meeting of the American Medical Association is being held in New York City, June 1-5, at Grand Central Palace. More than 15,000 physicians are expected to register, and about 30 other conventions will be meeting in New York City at about the same time.

Most important—**physicians will need a 1953 A.M.A. pocket card** to admit them to the Scientific and Technical Exhibits, as well as to the sectional meetings.

Scientific Papers

PANEL DISCUSSION: DIETS*

DR. SAMUEL McLANAHAN, PRESIDENT: We will now turn to the scientific discussion having to do with a panel on diets. There are blank papers in the seats for the purpose of preparing questions and it is hoped questions will come from the audience.

I will introduce briefly the participants in this panel.

The Moderator for our panel discussion of diets comes from Boston. We appreciate the distance that he has come and his preparation for this panel. Dr. George V. Mann is Assistant Professor of Nutrition, in the Harvard University School of Public Health, Boston, Massachusetts, and Assistant in Medicine at the Peter Bent Brigham Hospital. Dr. John Eager Howard, Associate Professor of Medicine, The Johns Hopkins University Medical School; Dr. Nicholson J. Eastman, Professor of Obstetrics, The Johns Hopkins University Medical School; Dr. R. C. V. Robinson, Instructor of Medicine, The Johns Hopkins University Medical School and Assistant Professor of Dermatology at the University of Maryland Medical School; and Dr. E. Cowles Andrus, Associate Professor of Medicine, The Johns Hopkins University Medical School.

DR. GEORGE V. MANN (MODERATOR): Dr. McLanahan, Ladies and Gentlemen, I am honored by this invitation to appear at the Baltimore City Medical Society meeting. I am perhaps a little overwhelmed by the distinction of the panel members sitting beside me. As some of you know, a few years ago I was a student of most of these people.

I would like to make perfectly clear my roll

* Presented before the Baltimore City Medical Society on Friday, November 21, 1952, at the Medical and Surgical Faculty Building, 1211 Cathedral Street, Baltimore 1, Maryland.

in the proceedings this evening. We have a relatively small group here in the audience, which should be an advantage for all of us because it will allow a good deal of participation. We are above all interested in practical matters and will try to minimize the theoretical aspects of science and nutrition and to emphasize the application of nutrition to pertinent medical problems.

Each member of the panel sitting here, as you recognize, has some particular specialty or interest in medicine, and each I'm sure has a wealth of experience and information to contribute to the problems to be discussed here tonight. We are not going to be able to discuss all aspects of diet as applied to medical problems. We will try to select—and it will be a somewhat arbitrary selection—certain of the problems which it seems are pertinent.

By way of an introduction, and in order that the panel may indicate in some way to you their particular interests, each participant will make some opening remarks to serve as a focus for your questions. Dr. John Howard will start with a discussion of obesity. Obesity perhaps more than any other problem deserves emphasis in a medical meeting because it can be said without qualification that obesity is the most prevalent nutritional disorder in this country. Furthermore, I doubt if there are any other nutritional problems for which we have as few really adequate and workable answers. I hope that some of these questions, perhaps unanswerable it is true, will be posed to this group before the meeting is closed. In the meantime, I would like Dr. Howard to give us some background for the discussion.

OBESITY

JOHN EAGER HOWARD, M.D.

I fear that there will be nothing new to you in my remarks tonight on the subject of obesity. Despite the intricacies and interrelationships of the chemical mechanisms in the anabolism and catabolism of carbohydrates, fats and proteins, one still cannot circumvent the laws of energy conservation; and a person who gets fat must take in more than he expends. Contrariwise in the process of weight reduction, the accounts must show a negative balance—a greater expenditure than intake of energy. This assumes, of course, that when one is speaking of weight loss or gain, the reference is to tissue; and in the subject under discussion, our reference is to excess adipose tissue. The scales often play us false and disclose water losses from the intra- and extracellular body compartments—a fact which accounts for the continued preying upon the public by multitudes of fake obesity cures involving sweating and diuretic agents; but the regimens of this type which show any lasting results are always accompanied by dietary restriction (of energy intake).

Perhaps it would be well here to remind you of the wide variation that occurs when individuals are restricted in their caloric intake. Most persons will, of course, lose water, rather rapidly at first, due largely to the fact that endogenous protein catabolism has been increased (to supply the energy deficit some protoplasm is consumed as well as stored fat) and there is coincident urinary loss of intracellular electrolyte and water. The scales will show in the first week a five or even a 10 lb. weight loss—to the elation of the unwary dieter. Subsequent weeks will show much lesser losses of poundage and some no loss at all, or even small gains.

There are also some individuals who will lose no weight whatever, even on the most perfectly organized reduction dietaries, for two weeks or

more. There will then follow a sharp weight loss; and at the end of a month or two, both types of individuals—i.e., the early fast losers and the slow losers—will be found to have adjusted their water equilibria to the new metabolic situations and both will have yielded about the same poundage. The point to be remembered is that the desired end in the treatment of obesity is to lose the excess *fat*. To accomplish this, the fat must be metabolically burned. Since fat is a high calorie foodstuff and yields approximately 9 calories per gram; and since from a practical point of view one can, in reducing regimens, only allow a deficit of about 1000 calories to be made up by body fat (a point to be discussed later), and since fat depots hold very little water (in contrast to protein and carbohydrate depots)—it may be seen that only about *100 grams of fat* can be burned off each day. Thus if we “reduced” in ideal fashion, that is, lose nothing but fat in the process and conserve all our substance (muscle, visceral protein, etc.), we should lose only 700 grams per week, or about 1½ lbs.

We cannot so regulate a diet, however, that in weight reduction of any magnitude some protoplasm (presumably useful) will not be coincidentally lost; but in planning a campaign to lose weight, it will be well to keep in mind that an average over the months of 2 lbs. per week is all that can be achieved without loss of tissues that one doesn't care to lose. The points to be emphasized are recognized by all who are experienced in treating obese persons, namely, that but little fat can be burned per day in terms of poundage, and that the frequently practiced daily examination of the scales reflects only water balance, leading to short-lived euphoria in some and depression in others. It is a wise rule to insist on weighing at intervals of two weeks to one month, for thus the inequities

of water metabolism will be smoothed out, and the menstrual water fluctuations will likewise be eliminated from the picture.

Before discussing more specifically the quantitative and qualitative aspects of dietary regimens, it would perhaps be wise to look briefly on what is known of the *etiology* of obesity. The negative aspects of this subject seem more clear than do the positive.

So far as we are aware, there is no basis in scientific fact for the still commonly held notion that uni- or multiglandular dysfunction is primarily responsible for the development of obesity, with the possible exception of Cushing's syndrome and hyperinsulinism. One cannot experimentally remove any gland or glands, nor can one inject any combination of glandular extracts, and thereby produce obesity in the sense that we are using the term. Hypothyroidism and myxedema are almost never associated with any real degree of obesity; in fact, when one sees a really fat person, underfunction of the thyroid can be practically excluded. This dictum has been so frequently reiterated that it seems astonishing that thyroid is still so frequently administered for the purpose of weight reduction. For it never accomplishes the desired end, since if small doses are used the patient's own gland functions just so much less and euthyroidism is maintained; whereas if intoxicating doses are prescribed, either unpleasant symptoms occur or body protein is excessively wasted or both. Weight loss from undernutrition is, of course, accompanied by a lowered basal metabolic rate and perhaps by reduced thyroid function, but this is a physiological adaptive process and had best be left uncorrected.

Pituitary insufficiency became connected with obesity in the minds of physicians because of its occasional association with destructive tumors in the hypophyseal area; and this was abetted by the observation of the early experimental brain surgeons that *some* of their hypophysectomized animals became enormously fat. It now seems

clear that coincident lesions of the hypothalamus are responsible for these so-called "pituitary obesity" cases. The legitimate term "Frohlich's syndrome," which is in reality a quite rare condition, has been so much misused and has for so long erroneously carried with it the concept of hypophyseal insufficiency as the cause of obesity that the term had best be dropped.

Experimental obesity has been regularly produced in several physiological laboratories by bilateral puncture of a very specific area in the hypothalamus. Though the metabolism of such animals has not been absolutely defined during the period of rapid weight gain and after the enormous obesity has been attained, it is evident that the major factor is the excessive appetite induced by the lesion. Operated rats, when allowed only the same quantities of food as eaten by their unoperated litter mates, do *not* become fat. The spontaneous and hereditary obesity in the strain of mice identified at the Bar Harbor Laboratories, though not of so severe a degree usually, seems to have much the same characteristics; but so far as I am aware, no specific hypothalamic lesions have been identified in this family of mice, about one-fourth of whom spontaneously weigh three or four times as much as their brothers and sisters if given a little more food to eat than the others naturally consume.

Certain features of these experimentally and hereditarily obese animals are worthy of comment. The excess weight is found to be entirely fat, the carcass weight being the same as that of litter mate controls. They are exceedingly prone to diabetes and degenerative renal disease, and their fertility is very low. Similar pathological tendencies are exhibited by obese humans, as evidenced so dramatically by life insurance statistics.

Obesity certainly does run in families, and whether this is due to an hereditary component in their hypothalami or simply an environmental result of early exposure to faulty habits of eating is not known. The striking frequency

with which childhood obesity begins following a tonsillectomy, appendectomy or an acute exanthem also gives food for thought. Has the trauma been purely an emotional one or has there been a coincident anatomic or physiological change in the "appetite center" of the hypothalamus? In this connection the psychiatric problems of the obese are also worthy of further investigation. Early in our interest in obesity, we were fortunate to have the collaboration of Drs. Diethelm, Rennie and Booth. In a study of some 30 fat persons, *all* were found to be suffering from severe emotional disturbances. This uniformity of association seemed more than coincidence; and, regardless of which pathological situation was the cart and which one was the horse, it became very obvious that in most instances such cases are better handled by the collaboration of an internist and a psychiatrist.

Whatever may be the primary defect which results in great weight gain, the only way we now have of attacking it is by dietary restriction. And so far as we now know, every case of obesity is amenable to this form of therapy, though the obstacles to success may often be exceedingly difficult to overcome. I once had a lady tell me, with a perfectly straight face, that she couldn't possibly lose weight by dieting since she had observed that during a round of golf she had gained more than 3 pounds without ever eating or drinking anything at all. One wondered how foggy or rainy a day it must have been for her clothes to absorb so much moisture.

Most persons lose weight exceedingly well if put on a 1400-1500 calorie diet in the Metabolism Ward of a hospital where strict and exact observations of intake can be maintained. It has long been the custom to make such diets high in protein (100 grams or more per day), mainly for the satiety value of this form of food but also with the idea of losing minimal quantities of body nitrogen during the period of weight loss. But Evans and Newburgh and others have used much lower diets containing only 500-800 calories with success and with

relatively small nitrogen wastage, at least after the first few weeks. It has seemed to us that the qualitative and quantitative nature of the diet (within limits, of course) are relatively unimportant features of the reducing regimen; that full understanding by the patient of the nature of the problem involved, his complete cooperation and the knowledge that small weight loss over a long period of time is the only possible harmless way—these are the essentials for success.

There are a few tricks, gleaned from experience, that may be worth noting. For some unknown reason, better results are achieved if the total caloric intake is divided into three even partitions, rather than having the patient eat a tiny breakfast and lunch in order to have a big dinner at night. It is remarkable how many obese persons follow the unbalanced intake method instinctively, and experimental evidence from rats indicates that food eaten all at a sitting tends to greater weight than if the same total quantity is consumed at three or four sittings.

One must watch out for alcohol. Many persons forget that the caloric value of alcohol is 7 calories per cc., so that 3 ounces of whiskey yield 315 calories. The "drink or two" before dinner not only adds dietary fuel, but usually also enhances appetite and removes inhibitions.

"Appetite killers," such as benzedrine or dexedrine, have been advocated as adjuvants to dietary regimens. They are also used for the emotional lift in relieving depression and to boost morale for dietary maintenance. It has not been our practice to use these drugs (and no collaborating psychiatrist so far has recommended them for any of our patients). In reality they are crutches to lean upon, and it is usually wiser to face and work out the long-term problem squarely.

It is unwise to yield to the plea: "Doctor, can't I diet six days a week and take a holiday on the seventh?", much like the Lenten Sunday. Experience has taught that this system is far

harder on the patient, and Sunday's overeating plays havoc with the adjusted metabolism as well as the emotional pattern of the dieter.

There is no rationale for restricting either fluid or salt in an obesity regimen unless such is indicated by some complicating cardiac or renal disease. Nor has it ever been clear to me why antidiuretic hormone of the posterior pituitary is given to help lose weight. Sweating procedures, widely used by boxers and wrestlers to meet certain weight deadlines, obviously have no place in the subject here under discussion. Actually the amount of calories so expended is exceedingly small, and the excess appetite engendered by the procedure usually more than negates its value.

Carefully outlined postural exercises, however, are often of great benefit. Great obesity is almost always accompanied by faulty body mechanics, especially lumbar lordosis with tense back muscles and weak abdominals and glutei. Correction of such postural defects reduces the waistline, promotes erect carriage and gives such a sense of increased well-being and assurance that it is highly recommended whenever feasible. Whether really true or not, I cannot say; but it has seemed to us that, when weight is being lost by dietary means, coincident development of weak muscles of the abdomen and pelvis has seemed to make the fat come off these areas more freely. Certainly our ultimate best results from the artistic point of view have been those patients who have exercised under the trained eye of Mr. Kendall at the Children's Hospital School.

Lastly a word about preparation of the diets. It has already been mentioned that protein should be a large constituent, fat and carbohydrate relatively low. The protein of shellfish—lobster, crab and shrimp—is ideally suited for such a purpose, being exceedingly low in fat, in contrast to most good lean meats which contain 15-20% of fat. But most important of all, the diet must be suited to the patient, both from the standpoint of palate and pocketbook.

Here the services of an expert dietitian are invaluable, and I gladly confess that any measure of success my patients may have had in their efforts to lose weight has been largely due to the expert dietary assistance which it has been my good fortune to have. All that I have had to do was to provide caloric figures and distribute them between carbohydrate, protein and fat; the dietitians in turn have translated them for the patients into palatable available food with reasonably high satiety value. Diet menus may be obtained in almost every movie magazine or ladies' journal, and in themselves they are usually well rounded and contain adequate vitamins. But they suit only the individual for whom they were designed, the menu soon palls on any other.

The latest wrinkle in "obesity diets" has come out of a sister city to the north. The basis of this is to eat a lot of fat, on the ground that the carbohydrate metabolism of the obese individual is so "set" that ingested carbohydrate goes much more to fat than in the normal person. Though I have had the privilege of reading the outline of this as yet unpublished (in detail) thesis, the basic physiological concepts did not to me seem to be consistent with the known facts. However, the diet, which consists mainly of lamb chops and high grade Western steaks, seems to achieve its purpose in bringing about weight reduction. But, when one calculates the intakes of the reported cases, it is found that these individuals have consumed about 1400 calories per day and lost on an average 2 pounds per week—just as have others on the more usual types of diets prescribed for many years. So no new metabolic or chemical theory need be evolved to explain the results obtained.

In looking back over these remarks on obesity, I find that most space has been given to matters other than dieting. And perhaps this is the correct perspective; because, although dietary restriction is the keystone of the weight reduction regimen—at least in the present state

of our knowledge—other factors than the prescribed diet are usually the cause of therapeutic failure. The successful regimen must be planned for the total individual, his emotions, his pocketbook, his palate; and if you are fortunate enough to have the collaboration of a dietitian, a physiotherapist and, if need be, a psychiatrist, your chances of achieving success for the patient will be greatly enhanced.

DR. GEORGE V. MANN: One thing is perfectly clear to me, Dr. Howard's cut at 300 pounds to discriminate between those who are obese and those who aren't is a considerably rougher cut

than we make in Massachusetts. Perhaps we can come back to this point later because—all levity aside—there is a very important point involved; the question of the change of body composition with age which may not be reflected in a greater girth or even in a greater weight on the scales but which is nonetheless a form of obesity. Let's leave that for a little later and turn now to Dr. Eastman. Continuing in the vein of the problem of obesity, he will discuss some of the practical issues which arise in the management of pregnancy as influenced by the presence of obesity.

OBSTETRICS

NICHOLSON J. EASTMAN, M.D.

Dr. Mann, Ladies and Gentlemen.

A number of studies have shown that women who weigh over two hundred pounds do less well in pregnancy than women who weigh, let us say, 140 or 150 pounds.

An analysis of those series of obese women will usually reveal, however, the following facts:

1. The average age of those patients is higher than the age of the child-bearing population at-large.
2. The average parity of those patients is greater than that of the average child-bearing woman.
3. The incidence of hypertension and of diabetes is higher than obtains in the child-bearing population-at-large.

Accordingly the poor results, the higher maternal and the perinatal mortality rates which have been reported for these obese women are attributable in part to these factors: Age, advanced parity, hypertension and diabetes. Nevertheless, in addition to these factors, obesity per se exerts a deleterious effect in the course of pregnancy and labor in several ways.

In the first place, the obese gravida is a poor anesthetic risk. Most women at delivery have some form of anesthesia and that question

inevitably presents itself. For instance, last Spring, we had a five-foot-two patient who weighed 343 pounds. She had a contracted pelvis and a cesarean section was mandatory. The anesthesia in that case was the main problem, as it often is in many of these obese women.

Over-weight women usually have pendulous abdominal walls. This pendulous abdominal wall allows the uterus to fall forward so that the long axis of the baby is not on a line with the pelvic axis, as it should be, and consequently, the head is not directed accurately into the pelvis. Hence, it is likely to be pushed to one side or the other and as a result of these circumstances, the incidence of abnormal presentations is somewhat higher in these obese women.

In addition, it is believed that uterine inertia and other difficulties in labor are somewhat more common. Accordingly, any obstetrician views with some misgivings, women who come to him weighing 250 or so and is more fearsome of the outcome than in the woman who weighs 130 or 140 pounds. As a consequence, efforts are made as a rule in very obese women to reduce their weight during pregnancy, and in moderately obese women to forestall the usual weight

gain which usually occurs in gestation. This often means dietary control by a competent dietitian.

For instance, some years ago I had a patient about twenty-two who weighed 258 pounds early in pregnancy. The dietitian managed to keep her content and happy yet reduce her weight to 220 pounds. At birth everything went quite normally and she gave birth to a nine pound perfectly normal baby. We use no medication in these cases, as a rule, but depend on dietary control.

Now, obesity is one thing and excessive weight gain in pregnancy is another. The situation I have been talking about is that of the woman who presents herself weighing from 200 to 300 pounds at the onset of pregnancy.

Excessive weight gain in pregnancy, that is, an increase of weight in a patient who starts pregnancy at 120 pounds and goes to 160 pounds is a different problem, although the management of it may be somewhat similar. If the weight of the baby, placenta, amniotic fluid, uterus, increase in the size of the breast, etc., are added up, a figure of something like thirteen pounds will be obtained which might be referred to as tangible weight gain. This is understandable. But when you recall that the average weight gain of pregnancy is twenty-four pounds, the question arises: What accounts for this additional ten pounds. It may be in some part fat, but it is chiefly water, as evidenced by the very pronounced weight loss which occurs in the early days of the postpartum, associated with night sweats and a profuse diuresis. Accordingly, when weight gain, especially sudden weight gain occurs in pregnancy, we are inclined to interpret it as waterlogging of the body. One of the purposes of prenatal care, of course, is to detect any evidence of the onset of the toxemias of pregnancy, such as edema, hypertension and

albuminuria. Insofar as edema is concerned, the weight gain of the patient is the most valuable index of latent edema.

Obstetricians try to restrict weight gain to about twenty pounds. Indeed, some authorities feel that this should be kept as low as sixteen pounds. In any event, it suffices to say that an attempt is made to keep weight gains down to a figure well under the average of twenty-four pounds; and it is my own feeling that efforts in that direction have resulted in a decided reduction in the incidence of the toxemias of pregnancy. Patients who gain less are freer from the usual complaints of leg ache, backache, and cramps in the latter part of pregnancy. This is to be expected since these complaints are due largely to the fact that those women who gain excessively have to lug around these additional pounds. Gravidæ who gain less do better in labor; they get their strength back sooner; and they also get their figure back sooner.

Time does not permit us to go into the ways and means of curtailing weight gain. It means often constant vigilance in the management of these cases together with encouragement. But when a patient, despite all reasonable advice still gains, chief dependence is put on meticulous management in the hands of a competent dietitian.

DR. GEORGE V. MANN: Let us leave the question of obesity for a moment now and turn to Dr. Robinson and his specialist's approach to another aspect of diet and disease.

Dr. Robinson will outline for us some of the pertinent problems in the field of Dermatology. I think particularly the things that we are interested to hear from him, and the questions of food allergy and its manifestations on the skin and some summary of the nature of that problem.

DERMATOLOGY

R. C. V. ROBINSON, M.D.

The concept that ingested foods may cause skin eruptions is not new. For many years, patients have presented themselves to physicians with the complaint that certain foods did not agree with them, causing hives or eczema. These claims were usually belittled or ignored completely. Even today the vast majority of the medical public refuse to believe that the skin may break out after eating anything.

During the past ten years, an increasing number of dermatologists and allergists have become interested in food allergy as a cause of various abnormal body responses. Figley and Rawling (1), in a symposium on the subject, state that "Food allergy is a clinical reality responsible for allergic rhinitis, asthma, urticaria, atopic dermatitis, and, less frequently, headache and gastrointestinal symptoms."

The antagonists of food allergy claim that either the phenomenon does not occur at all, or, if it does occur, the incidence is so slight as to be disregarded. They point out the high percentage of good therapeutic results without curtailment of diet and the failure of patch, scratch or intradermal tests to prove specific sensitivity to any one food. They have also suggested that it might be dangerous for someone not adequately trained in nutrition to curtail the diet of any individual patient for fear of causing serious nutritional disturbance.

It is true that frequently, by the judicious use of local medication and/or x-rays, remissions may be obtained. However, as every dermatologist knows, eczematous eruptions are prone to recur, and there comes a time when further x-ray therapy of any individual's skin is contra-indicated. In such cases, even the most adamant die-hard should be willing to give elimination diets a trial.

There is almost universal agreement that skin testing is of little or no value in determining specific food allergens. Circulating antibodies have not been isolated, and one allergist (2) has

stated that "Skin tests to foods, even when found positive . . . rarely indicate specific clinical sensitivity." This same author, who incidentally, is not convinced that food allergies cause important clinical entities, has noted that the emotional state of the patient may modify the skin reactivity.

Handled properly, the elimination diet never puts the patient in danger of nutritional disturbance. Even the most drastic basic diet is never maintained long enough to cause deficiencies. In most instances the offending substances prove to be non-essential, and, even if an important food item such as wheat, milk or egg, is found to be the allergen, there are adequate substitutes or supplementary substances to overcome the defect.

What evidence is there on which to base belief that food allergy does occur? Winston and Sutton (3) felt that foods were responsible for 30 of 388 cases of chronic, lichenified and excoriated, non-vesicular eruptions. Livingood and Pillsbury (4) agreed but added another 8 to 10 per cent in which diet was an important contributory factor. Flood (5) was able to prove definitely that ingested food allergens were responsible for fourteen of 65 hand eczemas, and suspected seven more. To those of us who believe in food allergy, proof lies in remissions obtained on withdrawal of a food and exacerbations when the same food is again added to the diet.

How is the offending food isolated, if no specific tests are of value? The only method of value is by a process of elimination. This may be done in several ways. A patient may be given nothing but milk for 48-72 hours. If the condition improves, a food or group of foods is added to the diet every day or two days. If the condition does not improve, the patient is given all foods but milk. This is not a good method since, in one series, 24 of 26 patients were found to be sensitive to two or more foods.

To remove one food at a time from the diet is obviously not practicable. A better method, but one which usually requires hospitalization, is the use of one of the so-called basic diets, in which the patient is given only a few selected foods which have been shown to cause low degrees of sensitization. To these, a few foods at a time are added. If symptoms are exaggerated, elimination and repeated addition of the suspected foods will cause remissions or exacerbations.

The most useful method is the use of an elimination diet in which the more common allergenic foods are eliminated. These are chocolate, citrus fruits, eggs, pork, sea food, tomatoes, nuts and milk. Some include wheat in this group. This diet allows sufficient variation and nutrient foods for any ambulatory patient on an out-patient basis.

A frequently raised objection to the theory of food allergy has been that most if not all allergens are proteins. Yet almost every physician has interviewed patients who complain of "strawberry rash" or "hives when I drink orange juice" or "I can't eat pork," or "chocolate breaks me out." One of the more vehement objectors to food allergies (6) has stated that "The common allergens are protean rather than protein."

Because vesicular eczematous eruptions of the hands occur with a fair degree of frequency, it has been suggested that rather than ingested substances being the cause, contact with the offending food may be the precipitating factor. In two studies (4, 5) this was carefully avoided, and the eruption still recurred when the food was given, and subsided when the food was eliminated.

One argument against food allergy was that if food allergens cause eczematous eruptions of the hands, they must be considered as possible etiologic agents in other eczematous eruptions, no matter what their localization. In one series (4), designed to study eczema of the hands, skin eruptions were found to be co-existing on feet, eyelids, legs, arms, face, scrotum, neck, groin, perianal region and axillae.

Ideally, elimination of proven allergens should afford permanent relief of symptoms. Practically, this is not true. An explanation which I, among others, offer is that the allergic pattern may change, the patient not remaining sensitive to the same food or foods, but the tendency toward allergy remaining.

There is not sufficient time even to open a discussion of psychosomatic factors which play a role in skin reactions, but I would like to mention that it is my firm conviction that, not only do psychosomatic factors play a great role in skin reactivity but that the combined effect of emotional lability and food allergy cannot be ignored. It is my experience that emotional tension or shock lowers the threshold of reactivity to certain foods. While control of emotions per se does not, in most instances, control the objective symptoms, it does lessen the itching tendency, which, with the elimination diet, will eventually cause control of the allergic response of the skin.

DR. GEORGE V. MANN: It must be obvious to you that you are getting more and more rope with which to express your questions a little later. Now let us have Dr. Andrus change the subject a little again, and review the general nature of a very large and very pertinent problem, that of the management of cardiac failure and edema, with particular emphasis on sodium metabolism and the role of diet in these problems.

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CARDIAC DIETS

E. COWLES ANDRUS, M.D.

Diet in cardiac edema is only an adjuvant to the other and often effective means of handling cardiac dropsy. The real problem of cardiac edema is the expansion of the extracellular fluid compartment, or the interstitial fluid.

To get back to the subject where Dr. Eastman and Dr. Howard left it, the reduction of obesity to ideal weight or slightly lower is completely necessary in patients with congestive heart failure. If you can get his weight down you have conferred that much reduction in his load. This is the result of certain equilibrium. There is intake through the mouth and stomach, output insensible of fluid through the lungs and output also through the kidneys.

The intake of fluid is regulated by thirst and thirst insofar as it is understood reflects actually the state of hydration of the body cells. But for practical purposes, it is regulated as are certain other important factors, by the effective osmotic pressure of this interstitial or extracellular fluid compartment. And the instrument by which the distribution of fluid in these compartments is principally regulated, is the body sodium.

Traditionally for a great many years it had been the habit of the profession to restrict fluids in patients with cardiac dropsy, and I think we are all regretful of the amount of discomfort which we have thus unwittingly caused patients with cardiac edema. Think of the thirst and distress which we evidently needlessly provoked. If sodium is properly controlled, the fluid intake of these patients can be vastly liberalized if not indeed allowed *ad libitum*.

The definitive basis on which our current conceptions of the role of salt in cardiac edema, are founded derives from some work which was done by Dr. Palmer Fitcher and Dr. Schroeder when they were at the Rockefeller Institute together.

In a patient who is otherwise normal the injection of 24 grams of salt is followed by a

sharp rise in the urine chloride and the weight gain is minimum. The serum chloride rises also. A dose of mercupurin given at the end of the procedure is only moderately effective.

However, take a patient with congestive heart failure, who has been treated and brought out of his failure and then is given 24 grams of sodium chloride.

In sharp contrast to the rapid and prompt elimination of the sodium chloride administered on the part of the patient with nothing more than bronchial asthma, there may be no sign of disposal of this, until later a rather large dose of salyrgan is given and even then a loss of urine chloride may not be as much as had been ingested.

We need not, I think, go into the still somewhat disputed area as to whether this retention of salt by the patient with congestive heart failure is the result of excessive absorption by the tubules from a normal urine flow or a reduced glomerular filtration presenting a smaller amount for absorption to the tubules. It is sufficient to say that in cardiac dropsy the regulating mechanism for the distribution of water and the size of the extracellular fluid compartment have somehow gone off the beam. Methods of treating this by the reduction of salt are by no means the perfect therapy, but, are so far among the best we can offer.

There are three general fashions in which this can be done. There is a diet of tradition, so-called Karell diet which was originally sharply defined, 800 cc. of milk. This would contain not more than a gram of sodium chloride. It can be augmented by fluid, but it should not be augmented, if one is to stick strictly to that regime, by other caloric material. It has an advantage that it is easy to give. It does not provide an adequate fluid intake and it by no means provides an adequate caloric intake, hence it cannot be kept up indefinitely, but it will sometimes tide a patient over a difficult point.

Beyond this it has become our habit to speak of gram and four gram salt diets. Roughly speaking if the individual's food is prepared without salt of any kind in cooking, and he avoids the obviously salt things, shellfish and canned vegetables and soups and meats that are prepared with salt, he will come out somewhere around two grams a day. Now, if the food is cooked with an ordinary amount of salt,—and that may vary from family to family—and no salt is added at the table, the patient will get four grams of salt or more a day. That is a considerable restriction when one considers that most of us have fallen into the habit of consuming from ten to twelve or more grams of salt daily. If such a restriction of salt is imposed or practiced, and if the patient faithfully lives up to it, the ability of the physician by means of digitalis, and the adequate use of diuretics if they are necessary, to control the reaccumulation of edema is considerably enhanced.

There is considerable current interest in substances which are intended to foil the absorption of sodium, namely, the cationic resins. These have a chemical avidity for sodium or potassium. They are usually ingested partially

saturated with potassium and it is intended that the patient's diet may be made more palatable and less restricted by their administration.

In some instances they work dramatically well. Sodium is retained by the resin but chloride is disproportionately absorbed, and a mild degree of acidosis regularly results but this is not intolerable in the favorable cases. On the other hand some of the cases which appeared to do best at first, namely those in which early in the phase of ingestion of resin there is a profound, pronounced diuresis, tend to go into renal insufficiency. These individuals cannot tolerate the administration of resins.

Resins have certain other disadvantages. The regulations of the bowel habits of the patient often becomes much more difficult, although it can be accomplished even when large quantities of resins are ingested. Finally they are expensive. There is no immediate prospect that the price will diminish.

One final word of caution: In this climate, in the summer time, when the insensible loss of water and salt is excessive, one has to be more liberal with the regime of salt in the diet and much more inhibited with the use of diuretics.

HYPERTENSION

GEORGE V. MANN, M.D.

We are now ready to commence with the real business of the evening, namely, the question and answer period. Before we start that, however, I'd like to indicate that the season is open for me, also in the question period.

I don't have a wide clinical experience, but because I suspect there may be general interest in the problem—and I think I overheard Dr. Howard say that Dr. Gofman was in town a month ago—I would like to describe briefly some of the work we have been doing in regard to lipid metabolism in arteriosclerosis and heart disease, especially atherosclerosis. I think that should be a part of this discussion tonight.

You may have heard that there is currently

under way, a large-scale study of the problem of atherosclerosis and the relationship of serum lipids to it. This problem was instigated about two years ago, shortly after Dr. Gofman first published his hypothesis in *Science*, relating certain substances in sera called lipoproteins to the presence and perhaps to the origin of atherosclerosis. The questions which he posed are several, but the fundamental ones are first, whether this material, this lipoprotein, is really of any greater importance, of any more significance in the diagnosis of atherosclerosis than is simply a measure of cholesterol or any of the other several indirect methods that we have.

As you may know, Gofman proposed that

measurement of serum lipoprotein was a considerably better means for this purpose than a cholesterol measurement. He further implied that in some way these substances are related to the genesis of atherosclerosis in humans. The answer to this question is difficult. We don't have the answer yet, but I would like to tell you briefly how we are trying to get it.

Four laboratories—Gofman's is one, ours is another, another at Cleveland under the direction of Dr. Page, and one at the University of Pittsburgh under Dr. Max Lauffer—are working jointly. We are doing a survey-type of study on a large number of individuals, probably about twenty thousand subjects will be measured. We are something over half way to that goal. We do a serum cholesterol measurement; we take a very brief clinical history which is designed to allow us to classify at least roughly into normal or otherwise and we do lipoprotein measurements by the ultracentrifuge technique.

We have found to our dismay that the accurate quantitation of lipoproteins is extremely difficult, more difficult I think than even Gofman thought when we started. You see, if we are to pool our data, it is essential that a sample of sera analyzed in each of the four laboratories would give the same result.

We found also that cholesterol measurements as conventionally done in hospital laboratories, including our own, were very unreliable. We further found that there was no available method for measuring cholesterol which would give adequate results, and this includes implicitly the widely used Schoenheimer-Sperry method.

A good deal of our time and energy then has been devoted to this problem of reliable measurements. This is a very important point because I suppose later on the question will come up, what is the normal cholesterol level in serum, and the answer is dependent upon the reliability of the methods you use. The four of us have done something over ten thousand measurements. We are particularly interested in those normal

individuals who, after we have done an initial measurement change their clinical status—that is have myocardial infarctions. We hope to be able to find one hundred such subjects. Then, having that group we can look back at our laboratory measurements, and we think be able to say which of these two measurements best predicted the event. We have no final answer to that problem.

In relation to the discussion of obesity here we have been doing some research on patients at the Peter Bent Brigham Hospital in an effort to find whether the treatment of obesity will have some influence on the serum lipid levels, and by serum lipids I mean cholesterol and lipoproteins.

The assumption is made here, that the serum lipids do have something to do with the origin of atherosclerosis. I am not sure that is true, but it may be true, and it probably is. We studied a group of thirty-nine people whom we were able to induce to lose an average of nineteen pounds.

Some of these people were overweight and some of them weren't. Some of them were initially at their ideal weight by life insurance statistical standards. We found that if the lipoprotein level in the sera—the S_r 12-20 class—was fifty milligrams per cent or more to start with; that we obtained a reduction when the patients lost weight, but if it were below that—and incidentally at least half of all the people in this room and all the population will be below that—then weight loss had no effect. Similarly for cholesterol. The break there was at about 300 mgs per cent.

Another way of saying this is, if the lipid level is initially high, cholesterol above three hundred, lipoprotein S_r 12-20 above fifty mg. %, then a weight reduction will lead to a reduction of the serum lipid levels. We imply, although we cannot of course prove that this is likely to reduce the rate of development of atherosclerosis.

I mention this work because I should like this topic also to be open for the question and answer period.

QUESTIONS AND ANSWERS

Q. Does obesity, per se, influence the glucose tolerance test?

DR. HOWARD: I can only answer that indirectly to say that I have never had the opportunity to do a glucose tolerance test on somebody whose weight is normal and then do it again on that patient a year later when she has gained fifty pounds. Going the other way, I think that if you take the average patient, you will find that a fair percentage of people who are overweight by considerable degree at least, have an abnormal glucose tolerance curve. But it depends much more on what that patient has eaten or not eaten the day before because that influences glucose tolerance curve enormously. If you take off a certain amount of weight from a fat individual, a fair percentage of those people will without any doubt have a lower tolerance curve when they are at a normal weight than they did when they were obese, provided they have been for a few days on a normal diet, not the reducing diet. But if you have somebody who is frankly diabetic, I have never seen anybody under those circumstances who has become non-diabetic by losing weight. The severity of their diabetes may improve and they may not have to take insulin when they have lost weight, whereas, they did require insulin before. But when you put them under stress, I have never seen one that didn't still have diabetes. I don't know whether that answers the question or not.

DR. MANN: It is interesting that the obese mice, the genetically obese mice which Dr. Howard mentioned earlier, apparently have diabetes as a complication of their obesity. Here is a question which I should like to answer or rather consider because perhaps I should have mentioned it a little earlier in the discussion:

Q. Nothing has been said about the quality of foods as deficiencies of vitamins and minerals and possible unknowns and the quality of soils in which foods are grown?

DR. MANN: We have said little here about what one might call the frank deficiency states, pellagra, scurvy and those things, and we will not have much to say about them principally because they are not a real and present problem in this country.

It has been but a few years since in the South at the Cincinnati General Hospital, for example, pellagra was a very common disease. Pellagra now in the South with a few possible exceptions in Mississippi, is a rare disease. In Boston at least, we have to depend upon City Hospital and chronic alcoholics for our teaching material illustrating the frank deficiency states with the exception of pediatric deficiencies.

Here is a question for Dr. Robinson.

Q. Of what value is diet in the control of acne?

DR. ROBINSON: In the first place acne doesn't have a single etiology. We know that in most instances acne appears about puberty, and usually the lesions begin to regress at about 21 to 25 years of age. We know that antibiotics seem to control it to some extent but we are completely ignorant of the actual cause of the disease. Many young patients come in with the complaint that chocolate causes new bumps; pork products and other foods, chiefly fatty foods, such as ice cream, are also offenders. In my practice, I have eliminated fats, and I think on a logical basis, because the sebaceous gland is the gland where the primary pathology of the condition lies. It is my experience that a low-fat diet and a diet low in certain other foods, such as soft drinks will cause acne to improve without any other form of therapy. Certainly we can't use X-ray in youngsters; I think every dermatologist will agree on that, and we are left with the treatment of acne by local means, and empiric means at best, and I think that diet should be added to that field.

For Dr. E. Cowles Andrus—Would you please discuss the low fat, low cholesterol diet with

reference to (a) its use clinically, (b) what clinical studies are necessary for intelligent application of this diet in suspected cases of coronary sclerosis?

DR. MANN: That's a very big order, Dr. Andrus. Would you like to take some section of it, any section of it?

DR. ANDRUS: No, I'm not as competent to answer that as you are. I'd like to hear what you have to say about it.

DR. MANN: I don't know the final answers to that and furthermore I doubt if anyone knows. There are several points that I feel rather strongly about. First of all, I think there is no evidence to support and there are several reasons to criticize anything approaching a mass application of the elimination of fat from the diet.

In the first place, there is good experimental evidence that we need not consider cholesterol and other lipids separately. Cholesterol at best is a poorly absorbed substance. It is particularly poorly absorbed when other lipids in the diet are minimal. It is unique among sterols in that it is absorbed at all; there are very few others that are. Vitamin "D" is a notable exception but this only in trace amounts.

I don't believe any of you or any physician should recommend to *groups* of people indiscriminately that they should restrict the fat in their diet. I do think there is a group of people largely undetected in this country who, while I cannot presently give proof, I believe would benefit by a restriction of the total lipid in their diet, and they are people with hypercholesterolemia. We imply a normal level of cholesterol in the serum. The latter is a very difficult thing to define, partly because of the complications of methodology. If you have a decent reproducible method it is reasonable to assume that a value of 300 milligrams percent or more in the serum, excluding a few exceptional situations such as the last trimester of pregnancy perhaps, or biliary obstruction, a level of 300 mg. % or more of cholesterol is an abnormality.

Furthermore, the clinical evidence suggests that people with these levels do develop atherosclerosis at an accelerated rate.

Furthermore, as I implied a while ago, these people with elevated cholesterol levels are also the people who will respond most readily to treatment designed to lower these levels. So far as I know, then, these are the only people to whom we can honestly and intelligently advocate a restriction of lipid intake, and in these people as the data of Keys, and ourselves and other people have indicated, it is not so much a restriction of cholesterol in the diet as it is the total lipids and calories which cause effective serum changes. If patients are overweight, they should certainly be reduced. Our experience indicates that it makes little difference whether they are overweight or not. If they would lower their body weight it will contribute to a lowering of their serum cholesterol and lipoprotein levels.

I am studiously avoiding any statements about the clinical implications of changing or trying to change the serum lipoproteins and cholesterol in human subjects.

If we have defined who should have his serum cholesterol lowered, at least in whom we should make the attempt, we are left with a dirth of methods to do it. I can give you nothing better at the present time than, in addition to weight loss, a suggestion that you try a low-fat diet. By low-fat I mean something less than fifty grams a day. Here, again, however, you will find considerable variation in the response. There are some people who habitually eat 100 to 150 grams of fat in a day, who will respond quite quickly when they are dropped down to 75, but by and large, it will take a reduction to fifty grams or less to accomplish a reduction of serum lipids.

There is a little evidence which only serves to confuse the picture that if you put subjects on an extremely low fat diet, analogous to that which they would receive on, say the Kempner rice diet regimen or some variation, then quite the

opposite may result, i.e., the serum cholesterol level will rise. Gofman has observed this. We have seen it occasionally. I think Dr. Watkins who is here might like to comment on it since, I believe, it was seen in the Goldwater experience.

You ask what chemical studies are necessary for an intelligent application. I think we have implied many of them; it is quite a task. At the present time adequate serum cholesterol measurement is essential. There are a good many people presently involved in the problem, trying to set up the perimeters and the definitions as to how you should proceed clinically in this situation. You see, I haven't really, and I don't think anyone can answer the most prevalent problem, namely, what do we do with a man age fifty, serum cholesterol 240 mg. %, who has either angina pectoris, or a proven myocardial infarction and is fifteen pounds overweight. What should we do with him? I don't know. I don't think I would persecute him with a low-fat diet. If it were myself, I would lose thirty pounds with the low calorie diet I could best tolerate.

I am impressed with the undocumented but still suggestive evidence that in parts of the world where people are chronically starved, chronically undernourished in relation to calories, there seems to be less atherosclerosis. In this respect it is interesting that we have been collecting the sera from Guatemalan Indians who live back in the mountains, still tribalized, who are largely vegetarians. We have measured about 125 of these. They have very low serum cholesterol levels, equivalent to those we find in children in this country—125, 150 and rarely over 160 mg. %. Now I don't know the reasons for this, and I don't even know whether these people do have atherosclerosis. We are trying to find that out.

DR. ANDRUS: May I make a comment, Dr. Mann? The serum level of cholesterol of three hundred, unless the method is very carefully controlled, may include a larger segment of the

population than perhaps you intend to apply this to. Could you give us an idea what proportion of the individuals in the cooperative study had a serum cholesterol of 300 or over.

DR. MANN: Since I am not privileged to speak for the Cooperative Group data I will only refer to data gathered in our own laboratory. I'm sorry I don't have here before me the table of normal values derived from about 500 observations on males between the ages of thirty and seventy, but as I recall, we found that less than sixteen per cent of those males of all that age span have a value of 300 milligrams per cent or more. These are randomly selected people insofar as we can acquire them. That is, it is not a hospital population we are sampling. They are largely industrially employed people. This says that sixteen out of 100 people would fall into the category of subjects who, I am contending should have some studied efforts made to lower the serum cholesterol.

Taking the entire population, it gets to be a considerable number. Adlersberg, studying largely a Jewish population in New York has estimated that perhaps as many as five per cent of the male population is hypercholesterolemic. All our evidence would suggest that 300 milligrams per cent is a reasonable place to make the cut, and something like 60 milligrams S_{12-20} lipoprotein, but I shouldn't give much weight to that at the present time.

Q. Baltimore is the only major city in the country which does not permit the sale of skimmed milk. The reason given by the Health Department is that mothers would use the product to feed babies. Is there any evidence that butterfat is necessary or desirable for infant feeding, and would the panel discuss the ban on skimmed milk?

DR. MANN: First, I'd like to hear Dr. Eastman's comments on the question of baby feeding.

DR. EASTMAN: Not being a pediatrician I cannot answer the question about feeding of

babies, but the question does come up not infrequently in regard to dietary management of pregnant women in whom you want to maintain adequate calcium and phosphorus intake and yet reduce calories; and for long years skimmed milk has been utilized for that purpose. All that is necessary is to write a prescription for "skimmed milk—one quart a day" and she receives it from the dairy.

DR. MANN: There is a question here directed to Dr. Howard.

Q. What effect does the high-protein high-fat diet for the treatment of obesity have upon the cholesterol content of the blood?

DR. HOWARD: Reference is presumably made to the Pennington diet with which we have had no experience. However many reducing regimens are really high protein, low fat diets, for the reduced calorie intake requires expenditure of energy from the body stores and this is furnished either as protein or fat. Thus the metabolic mixture actually burned by a person on an undernutrition regimen is high in protein and fat.

I have no figures as to what happens to the level of serum cholesterol in our patients who have lost a lot of weight by dieting. Some, however, who started with high cholesterol levels, did show fall of cholesterol concentration coincident with weight loss.

DR. MANN: We have tried to answer this question in some work done with Dr. Olson of Michigan State College, but we really have never gotten the answer. We have considered this problem from a little different point of view than that stated by Dr. Howard. Because our hypothesis is that in the human dietary cholesterol and neutral fat should not be distinguished since cholesterol absorption is dependent on diet fat. The crux of the relationship is in the intestinal tract, and while it is true that when you reduce a man on a low fat, low calorie diet you are forcing him to metabolize a high protein, high fat metabolic mixture, the fact is that in that individual you are also minimizing reabsorption of cholesterol.

We know, for example, that a considerable amount of the cholesterol absorbed arises from the biliary secretions, so that I'm not sure but that the question posed here may involve some fundamental physiology which is very pertinent to the entire problem. To my knowledge the answer isn't available.

Dr. Robinson wants to defend himself here. I think he is sensitive to the remark that a child developed a vitamin "A" deficiency while on an elimination diet. Is that right, Dr. Robinson?

DR. ROBINSON: Yes. It is hard to conceive that a child 2½ months old would not have had a pediatrician, and secondly, it seems hard to conceive that all of the vitamin "A" in that child's diet would have had to depend on milk, because I think it is almost universal now to give supplementary vitamins to an infant. I think the dermatologist was at fault but I also think the pediatrician should share the blame.

DR. MANN: Let us turn to the question of hypertension, because I'd like very much to hear what the experts have to say about the dietary management of hypertension. You are no doubt aware that for thirty years there has been quite a little struggle both as to the origin of the idea and the clinical effectiveness of dietary salt restriction in the course of hypertension. The whole issue was re-precipitated so-to-speak when Kempner published his "rice diet" proposal.

Q. I'd like to ask Dr. Andrus what the status of the rice diet per se is and whether there are some more benign alternatives to a diet of rice and fruit juice.

DR. ANDRUS: This depends a little bit upon where you sit. It works very well in Durham, in a fair proportion of instances, and I accept that as a fact. I think one reason why it works at the hand of Kempner and in that environment is that you have to get religion to live on it. You have to develop a cult of individuals who are worshipping that particular method of living. It appeals to the obsessiveness and to the compulsiveness of some individuals, and it is that

type of individual who frequently develops hypertension. When properly attended to, it undoubtedly may afford a useful therapeutic tool, though to be candid, I would despair of conducting a case of hypertension indefinitely on the rice-fruit diet myself. We have had a few patients in the cardiac clinic at Hopkins, whom we have had on the diet and who followed it and who got evident benefit. The Goldwater experiment to which Dr. Mann has referred, and in which Dr. Watkins took part, I believe, represented a carefully controlled biological examination of the effects of the rice and fruit regime. The diet has another disadvantage—believe it or not—in this country a rice-fruit diet is relatively expensive.

Whether it is the low protein or low salt or some other factor in the Kempner diet which produces the advantage when it does have an advantage, one cannot say but certainly you get similar effect in hypertension if you can persuade an individual to live on a diet which is as low in salt as the rice-fruit diet is. You have to get down pretty low, to half a gram or thereabouts, and it is a pestiferous diet to prepare and an uncomfortable diet to live on.

There is one phase of danger of both these regimens with which I am sure you are not unfamiliar and that is that if you are misled into applying a low salt regimen in the case of hypertension with kidney damage, which happens to be a salt-losing nephritis in disguise, you are in trouble very soon.

DR. MANN: Do you think it is safe and reasonable to put a patient on such a restricted diet without laboratory control?

DR. ANDRUS: I certainly do not.

DR. MANN: By laboratory control I mean serum electrolyte measurements and not, say, urine chlorides.

DR. ANDRUS: Certainly. I don't think you can prescribe such a diet empirically at all.

DR. MANN: And I presume the same would apply to the use of ion-exchange substances?

DR. ANDRUS: Certainly, I should have emphasized that.

Q. (For Dr. Eastman) Who among pregnant women should have vitamin supplements or should they all?

DR. EASTMAN: In my opinion, some kind of a crusade should be started to teach doctors, medical students, nurses, pregnant women, drug salesmen, writers of advertising matter for drug houses and writers of commercials for radio and television that pregnant women do not need vitamin pills, or calcium and phosphorus pills. It is my own feeling that a diet in which there is a liberal amount of meat, milk, fruit, and green vegetables is altogether adequate. On the other hand, current trends would seem to indicate that iron supplements are desirable. Only diets which are very rich in meat seem to meet the iron needs in pregnancy, and for some years now, we have been giving routine iron supplements to all our pregnant women; and as a consequence we have found that iron deficiency anemias are much less common than formerly.

DR. MANN: You do recommend iron, and it brings to my mind a question which is plaguing some nutrition circles. Should the iron have also a little copper and a little molybdenum thrown in? The molybdenum question I'm especially interested in because I think that idea originated or at least received some substantiation in an obstetrical clinic in Chicago. What do you feel about that?

DR. EASTMAN: I'm not competent to discuss the theory of the advantages of molybdenum and copper along with iron. However, the preparation which I have used for a good many years is the very preparation which you are mentioning and which goes under the trade name of Mol-iron. The "mol" refers to the molybdenum. I find that this preparation is perhaps more acceptable to patients and is a little freer from gastrointestinal irritation.

DR. MANN: Dr. Howard would like to hear more of the question of what we might call occult obesity developing with age. We men-

tioned it a little earlier, the tendency for muscle tissue to be replaced with fat as one grows older and thereafter the tendency to be misled by what the scales say. And if one actually weighs at age fifty what he weighed at age twenty-five to feel that therefore one is not obese.

Just to fill in a little background, this problem came up for intense study during the last war when one of the armed services was interested in physical appraisal and the adaptation of fighting men to their tasks. Studies were undertaken to try to ascertain body composition. A most horrendous, but I understand a fairly effective, method was used. It involved weighing an individual in air and weighing him submerged in water. Some interesting facts developed.

For example, members of a professional football team were found to be almost unanimously obese by scales and insurance company statistic ratings. But it was shown that according to density measurements their excess weight was not fat but protoplasm. As fat replaces protein tissue, fat having a considerably lesser density, specific gravity measurements will reveal this. A good research problem is the development of an adequate and simpler technique for readily appraising body composition, perhaps by some dilution method. This is a point of considerable interest.

Dr. Howard, would you like to make some comments on that?

DR. HOWARD: No, I really wanted to hear the question answered because when I was in Medical School, the Insurance tables still said as you grew in age, your weight could increase. That was a normal thing. The weight of a fellow at 21 would be one thing and at 50 quite another. Actually about twenty-five pounds was the difference. Now, you add to that the fact that as he grows older and doesn't exert himself as much, even though his weight doesn't change, he changes considerably in the relativity of fat to protoplasm. Do you take that into account in your nutritional thinking?

DR. MANN: In the first place I hope it is clear

to everyone that when we talk about ideal weight as derived from life insurance tables, those tables are derived from a performance assay—that is to say they are derived in a sense of a weight at which a group of people did best in terms of health and longevity. These have been supplemented a little recently with some additional information which I think is subject to some statistical criticism, which says that people who lost weight do better health and longevity wise thereafter.

In the sense of the specific question that Dr. Howard has put: do we take into account this tendency to dilute the body substance with fat with age. I think the answer is no, that our techniques are far too crude to include what is really at the present time practically speaking an immeasurable quantity. We have no feasible way at present. It is not possible obviously to weigh patients routinely in air and in water. Furthermore, the gravity measurement is dependent upon certain rather difficult assumptions as to contained gas, for example, ventilatory gas and gas in the intestinal tract. So that the answer I think is no, we cannot take it into consideration, but we are interested in the problem and expect one day to be forced to face it. We suspect that it may be part and parcel of this whole problem of obesity.

Q. DR. MANN: Someone asks the question of Dr. Howard, What about methyl cellulose in appetite control? And Dr. Howard tells me in an aside that he doesn't know. He never heard of methyl cellulose.

Now I have heard of it because I have been listening to Gaylord Hauser occasionally. (Laughter) He has emphasized this methyl cellulose, a common synthetic and easily obtained material which has the chemical characteristic of taking up a large amount of water. It swells just preposterously in water so that if you eat a little of it, say a couple of good big tablets of it, when they get into your stomach they take on so much water that in twenty minutes you feel as though you had eaten a turkey dinner. That bloated

feeling does apparently have some inhibitory effect on your appetite. It's a crutch which encourages all concerned to neglect the basic issues.

That is one way to take our appetites away. I think there was a report recently in the *Journal of the American Medical Association*, of a patient with an esophageal obstruction after taking one of these things.

I'd like to ask Dr. Robinson a point of information for myself. The question of cutaneous xanthoma. The issue has often been raised whether these xanthomatous lesions seen sometimes on the skin are not an easily observed manifestation of the same disease which occludes coronary arteries. I'd like to know from him first whether he believes there is some morphologic relationship between these two manifestations, and more important, to what extent the cutaneous manifestations vary either spontaneously or with diet therapy?

DR. ROBINSON: The most common of the group is xanthelasma, and xanthelasma is found in a particular group of individuals; those who

are overweight and those who have become overweight at a fairly early age. Whether or not that group of individuals might be more prone to arteriosclerosis, I can't answer definitely because while xanthelasma has been most frequently associated in text books with diabetes, I have not found that to be true. There are about eleven xanthomatoses among which would be xanthoma tuberosum multiplex. Whether or not it is associated with internal manifestations, has not been established.

DR. MANN: Are there any questions? Any oral questions that you would like to fire up here? The hour grows late. I think you will not often have an opportunity for such expert opinion as you have here. If there are no questions, then I would like to thank the Medical Society for the opportunity they have given us, and turn the meeting back to its President.

DR. McLANAHAN: The Medical Society would like to thank you, Dr. Mann, for coming and the participants, and the members for being here and giving us this program.

Good night, the meeting is adjourned.

CLINICAL PATHOLOGICAL CONFERENCE*

CHARLES W. WAINWRIGHT, M.D.¹ AND MORGAN BERTHRONG, M.D.²

Clinical History #593,713 F. A. J. Married. White. Male. Age 43. Admitted: Dec. 24, 1951. Died: Dec. 27, 1951.

Complaint: Shortness of breath over a period of two weeks.

Family History: Unimportant.

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Past History: Typhoid fever at age of 23 years; scarlet fever one year before admission, otherwise he had enjoyed good health. As a Civil Service worker had had frequent physical examinations including chest x-rays. So far as he knows, never had any elevation of the blood pressure. Always rather heavy, about 220 pounds, but during the year before the present illness had reduced his food intake and had brought his weight down to about 185 pounds.

Present Illness: In retrospect the patient thought that probably for five or ten years prior to the present illness, he had noticed increasing dysp-

nea after vigorous exercise. About four months prior to his admission he had become quite dyspneic on the slightest exertion and this lasted one or two hours. It passed off uneventfully and did not recur. Two weeks before admission he developed a cold and had some cough productive of small amounts of clear sputum, and with the cough he developed increasing dyspnea, so that he would become short of breath with as little exertion as walking the distance of one block on the level. He never had expectorated blood and had no pain in his chest. He could sleep lying down and was never dyspneic at rest. Three days before admission he awakened to find that rather suddenly he was much more short of breath as compared with the preceding day; in fact he was too short of breath to answer questions or talk, and he found it difficult to dress himself. For the first time he became conscious of palpitation associated with his dyspnea but denied the presence of any chest pain or substernal pain or oppression. He saw his physician who found his temperature to be 97°, noted the dyspnea and found his blood pressure to be 130/110. Patient was admitted to a local hospital. There was no cyanosis but the neck veins were distended. An x-ray of the chest was made which showed "infiltration extending out and up from the left hilum." He was given Penicillin. The next day he was somewhat cyanotic and the pulse was accelerated, the rate being 120. He was given nasal oxygen and put on digitalis, but without any improvement. He was brought to Baltimore and admitted on the surgical service of the Johns Hopkins Hospital, with the provisional diagnosis of a mediastinal mass. Six hours later he was transferred to the medical service. He had had no pain, no edema, no chills or fever, and the only difficulty of which he complained was the dyspnea.

Physical Examination: Temp. 101°. Pulse 100. Resp. 20. Bl.P: 101/80 equal in the two arms.

The patient is described as a heavyset and large chested man, lying flat in bed, breathing rapidly. Sitting up produced no decrease in his

respiratory rate; he would have to stop in the middle of a sentence to catch his breath. The face was ruddy. There was no glandular enlargement except for some small cervical nodes. The pupils reacted actively to light and during accommodation. The extraocular movements were normal. The fundi were described as normal. There was a slight nasal discharge but no obstruction. The pharynx was considered normal. The neck was supple. The trachea in the midline; no venous distension in the neck was noted. The chest was large with some increase in the antero-posterior diameter, but the lungs were clear to percussion and auscultation. The diaphragms moved well and there were no adventitious sounds heard. The left border of the heart extended to the midclavicular line. There were no shocks or thrills. The heart sounds are described as distant and of only fair quality. The second aortic sound was louder than the second pulmonic and along the left sternal border, in the fourth interspace, there was a split second sound, the second component of which suggested an early diastolic murmur to the examiner, but only in certain phases of respiration. This was not definite and no other murmurs were heard. The liver edge percussed to the costal margin. There was no abdominal tenderness or mass. The spleen was not felt. The genitalia showed nothing abnormal. A rectal examination was not made. There was no clubbing of the fingers. There was no cyanosis, and no edema of the extremities. There were good pulsations in the vessels of the feet and the reflexes were normal. There was no motor or sensory disturbance.

Course in Hospital: The patient was put at complete bed rest and given oxygen by catheter. The following day he seemed somewhat less short of breath, but he still would become dyspneic on talking. There was no orthopnea. The venous pressure was 130 mm of water and the circulation time, arm to tongue with dechalin 30 seconds. The blood pressure was lower, having fallen to 90/60. The following day the patient, rather suddenly, became much more short of breath and

his blood pressure was 88/70. At that time the venous pressure was 150 mm of water and the circulation time had increased to 75 seconds. The lungs remained clear on physical examination but the gallop rhythm had become more pronounced. His cough tended to increase and he complained of some substernal irritation which was thought to be aggravated by coughing, and he also complained of lower abdominal pain, but nothing further could be found on physical examination. Later that day he vomited. This greatly increased his shortness of breath and caused a recurrence of his abdominal pain. The splitting of the second pulmonic sound seemed more pronounced. The pulse rate was 120; respiration was labored at a rate of 28. The lungs still remained clear. The abdomen was soft, there was no spasm or rigidity, but still some tenderness in the left lower quadrant but no rebound tenderness. Oxygen which had been administered by catheter then was changed to a tent. This made him much more comfortable. The possibility of a pneumonia was considered and antibiotic therapy was instituted with Aureomycin. He also was given digitalis. His condition grew progressively worse, the shortness of breath increased and he was increasingly cyanotic. The heart was still not enlarged but the sounds now were considered of mushy quality and further comment is made of the existence of the protodiastolic gallop. The liver was thought to be somewhat enlarged and the veins of the neck became distended. Still the lungs remained entirely clear on physical examination. There was no edema of the lower extremities but the note is made that the right calf was $1\frac{1}{2}$ cm larger in circumference than the left, but there was no tenderness. His condition grew steadily worse; his blood pressure was unobtainable, and he became very excited. This increased his dyspnea and terminated only when he collapsed, and death following in about five minutes.

On admission the temperature was 99° by rectum; in four hours it had reached 101°, and it varied between 100° and 101° for the next

forty-eight hours when it reached a maximum of 102°, falling rapidly before death.

Laboratory Data:

Dec. 24, 1951	Blood: Hemat. 49. SR 10. WBC 13,000. PMN 64%. Lymph. 30%. Mono. 6%
	Smear shows no abnormal cells and platelets are adequate
Dec. 24th	Urine: Sp. Gr: 1.015. Acid: Sugar 0. Alb: Trace
	Occasional white cells, no casts
Dec. 25th	STS; Negative
Dec. 25th	Blood culture: Negative
Dec. 26th	Blood chemistry: NPN 45 mgm%. Sugar 92 mgm%. T. Prot. 6.9 gm%. Alb. 4.2 gm%. Glob. 2.7 gm%
Dec. 27th	NPN 54 mgm%. Sugar 132 mgm%. CO ₂ 22.1 m/eq. Chlor. 101 m/eq. Potas. 5 m/eq.

Electrocardiograms:

Dec. 24th	Rate; 94, P-R interval: 0.19 sec. Rhythm: S-A. P waves normal. QRS complexes: Tiny, variable Q3. Maximum deflection in limb leads (5.5 mm in Lead 1). T waves: Inversion T3, V1 and 3. ST segments normal. QT interval 0.38. R-R 0.66 (prolonged). Interpretation: QRS amplitude at lower limits of normal. Q-T interval prolonged. Digitalis "effect."
Dec. 25th	Since the record of Dec. 24th, 1951 the Q3 has disappeared. QRS amplitude is still at the lower limits of normal. Q-T interval 0.44. R-R 0.76 (prolonged).
Dec. 27th	Rate: 94. P-R Interval: 0.16 sec. Rhythm: S-A. P waves normal. QRS complexes: Low voltage in limb leads. Delayed precordial transition. Vertical axis T waves: Sagging ST 3 and V1 with inverted T waves. T2 low, upright. Q-T interval 0.40. R-R 0.68 (slightly prolonged).

Interpretation: Low voltage in limb leads. Prolonged Q-T interval. Abnormal T waves.

X-ray Outside film³

X-rays: J. H. H.

Dec. 24th Chest: There is an irregular infiltration in the left lung field near the hilum apparently localized in the apical segment of the lower lobe. The lung fields otherwise are clear. The heart and great vessels are within normal limits. The etiology is suspected to be of virus pneumonia although a neoplastic process cannot be excluded.

Dec. 25th Chest: There has been some resolution of the infiltrative process in the left lung as compared with the previous films of the day before, although this still does not exclude a tumor, it gives more support to the impression of pneumonia.

SUMMARY

DR. WAINWRIGHT: We'll have the x-ray, please. This film of the chest shows the shadow coming out from the hilum on the left side, Fig. 1.

Now then, in summary, we have a forty-three year old white man, who, for several years, was becoming increasingly short of breath, and four months prior to admission experienced a short, rather acute attack of dyspnea which passed off uneventfully. Two weeks before admission he developed an upper respiratory infection which greatly aggravated his dyspnea but did not provoke cough, hemoptysis or pain. He was singularly free from orthopnea. The day before admission he was awakened by extreme dyspnea and was now aware of palpitation. His physician

found him short of breath with distended neck veins but not cyanotic, with a high diastolic pressure and a small pulse pressure. The only cyanosis commented upon was on the next day and it evidently was not profound; and at this time the infiltration that you have seen in the x-ray was described.

Thus far he had no fever, but on admission to the hospital in Baltimore his temperature was found to be 101°, and his blood pressure had fallen to a much lower level. His dyspnea was extreme but there was no orthopnea and no cyanosis. The veins of the neck were not distended. Although the chest was large it was not emphysematous, and on physical examination was found to be entirely clear. The heart was not enlarged, the sounds distant and of poor quality, a gallop rhythm was heard, there were no murmurs, and the second pulmonic sound was not accentuated. The liver was not enlarged and there was no edema.

The patient's course in the hospital was a stormy one, he lived but three days after admission, and had fever with a slight leukocytosis all the while. He continued to be dyspneic but was not cyanotic. His venous pressure was only slightly elevated, but the circulation time was quite prolonged and materially increased while the blood pressure remained low. The lungs remained clear on physical examination even though the respiratory rate and the pulse rate increased, and his respiration became more labored. The gallop rhythm persisted and became more pronounced, and the heart sounds became of increasingly poor quality and are described as "mushy." He developed lower left quadrant pain which persisted, but nothing beyond some localized tenderness was found. As he rapidly became worse, congestive failure developed and he died.

The laboratory data accumulated showed little that was of aid in the diagnosis. The x-ray of the chest showed a shadow in the left lung field which you have seen. The electrocardiographic studies showed variations from normal and ap-

³ Dec. 22nd Chest: A chest film taken this date at St. Mary's Hospital, Leonardtown, Md. (two days before films at this hospital were taken) also reveals an infiltration extending from the hilum into the upper lobe on the left. The film is light, making it difficult to see much difference between the two sides on this particular film. The findings are essentially those as reported here on Dec. 24th and Dec. 25th, 1951.

peared to be more than the digitalis he had received could account for. There was a tendency to right axis deviation though this was by no means distinctive. The changes were not specific but would appear to indicate that his heart was laboring under great strain.

condition which might be considered is a mediastinal tumor. The possibility of this is suggested in the appearance of the chest by x-ray, and to the roentgenologist the shadow coming out of the left hilum was capable of this interpretation. To suggest it, however, is to dismiss it, for the

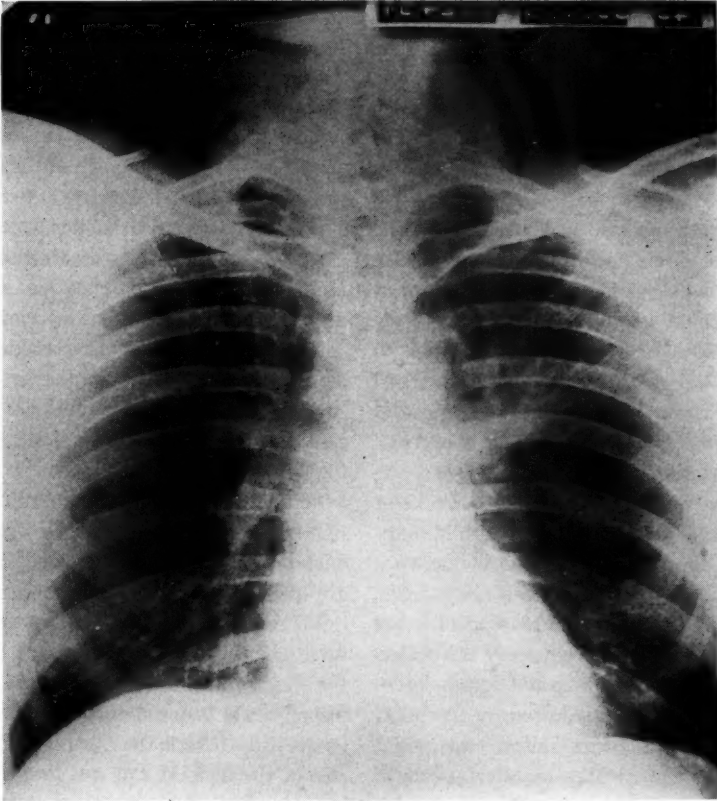


FIG. 1

DISCUSSION

DR. WAINWRIGHT: In the discussion of this case we must consider the problem in three ways.

1) Was there anything within the mediastinum but without the heart or lungs which caused this difficulty? 2) Was the cause of his trouble primarily pulmonary? 3) Was the condition which produced his symptoms and caused his death cardiac?

With regard to the first question the only

history is much too long; and to have experienced such a degree of dyspnea from a mediastinal tumor there surely would have been obstruction of the trachea with stridor and most surely other evidences of a space occupying mass.

The decision as to whether his condition was pulmonary or cardiac is more complicated, and one must consider both chronic and acute lung conditions in seeking a pulmonary origin for his symptoms and signs. Of the chronic pulmonary

conditions, emphysema with its accompanying chronic basal infection and interstitial fibrosis of the lung would merit consideration.

Although the patient had had increasing dyspnea for four or five years, it was not the story of emphysema and chronic bronchitis, and exacerbations with each recurring respiratory infection. His chest is described as being one with increased anteroposterior diameter but it was not found emphysematous* by x-ray. Cough and sputum were conspicuously absent, and whereas the lack of orthopnea would suggest that his dyspnea was pulmonary in origin, the results of increasing obstruction to the pulmonary circulation were not present. There was no accentuation of the second pulmonic sound, no chronic cor pulmonale, or a failing right heart. There was only dyspnea on exertion without cyanosis, with his capacity for activity steadily decreasing.

Interstitial fibrosis of the lung was described originally by Hamman and Rich as acute and was a diffuse thickening of the alveolar structure, producing obstruction to the pulmonary circulation. The course was often a matter of weeks or months, but was acute as such diffuse pulmonary disease goes. The pulmonary phase of the condition was dominated by dyspnea and cyanosis, but often the patient was not seen until heart failure had developed, and frequently the underlying pulmonary difficulty was not appreciated, being so completely over-shadowed by the heart failure. However, the heart failure was right sided with all of the cardiac manifestations of obstruction of the pulmonary circulation. In this instance what would have to be considered as the pulmonary phase of the disease was long, four or five years. Cyanosis was not present and right-sided heart failure appeared only as a terminal event. In either pulmonary fibrosis or in emphysema, obstruction to the pulmonary circulation is the mechanism by which the condition leads to a fatal determination. It was lacking in this case, and diffuse pulmonary disease would have produced a picture quite different from the case in hand.

As to any acute pulmonary condition, one would consider a pneumonia or pulmonary embolism. The onset of his terminal illness was not that of an ordinary pneumonia and the fact he had no fever for forty-eight hours after the onset would be most unusual in pneumonia. Furthermore there were no signs of consolidation on physical examination, the intoxication of the disease was not present, and cough, sputum and hemoptysis were likewise lacking. If the shadow shown by x-ray was an infiltration, it was central, which would account for the lack of physical signs, and would suggest an atypical or virus pneumonia. If such was the case here, one would surely have to consider some affection of the myocardium concurrently present, and that the pneumonia threw the balance in an unfavorable direction so far as his cardiac compensation was concerned. One might also consider the extension of a virus pneumonia to the myocardium, but such a viral myocarditis would not account for the antecedent history of increasing dyspnea over four or five years.

With regard to pulmonary embolism one cannot be too sure. The sudden onset of dyspnea without pain and the delayed febrile response are quite like pulmonary embolism. The signs of infarction were not present, but this is dependent upon the amount of pulmonary congestion and the shadow in the left hilum could well be pulmonary vessels brought into prominence by embolism. Also, there is the matter of the difference in size of the legs. It was not great and may have been of no significance whatever. A fatal pulmonary embolus is a large one, and the thrombosis of a leg vein responsible for a fatal embolus would be expected to produce more edema than was the case here. It is, however, the course of events which is unlike fatal pulmonary embolism. A large straddle embolus may cause death with such rapidity that the usual manifestations, dyspnea and cyanosis, do not have an opportunity to appear. Others go for longer periods when dyspnea, cyanosis and shock do manifest themselves and death is a more profound respira-

tory struggle, and the cardiac manifestations are those of acute cor pulmonale. Smaller emboli occlude only branches of the pulmonary artery and do not cause death, but such circulatory strain as they produce also falls upon the right heart. There was no evidence of right heart strain here unless the small right axis deviation could be considered as such. This was the only evidence that could be regarded as indicating any degree of obstruction to the pulmonary circulation. Furthermore once a pulmonary embolism has occurred and is survived, the patient improves, whereas this man steadily grew worse, but never with evidences of congestive failure until shortly before death which came after four days. Again a small and non-fatal pulmonary embolus might create sufficient embarrassment to an already damaged heart to tip the balance toward increasing failure.

As to the consideration of the third possibility; was this patient's fundamental difficulty with his heart; it does not appear that he had a long-standing hypertension as his heart was not enlarged, but this does not preclude the possibility of arteriosclerosis of the coronary arteries. In the absence of chronic pulmonary disease to account for his increasing dyspnea over four or five years, one must conclude that his myocardium was at fault. One is struck by the lack of orthopnea as his dyspnea increased, and even more by its absence after entering the hospital here, but right sided failure never was conspicuous until terminally, as indicated by the slight degree of increase in venous pressure. On the other hand the circulation time was high on admission, and quite definitely increased during the remaining days of his life. One would take this to mean that his heart was having difficulty in emptying itself but had not yet reached the point of backward failure, with congestion of the venous circulation, or that the circulation of the lung was impeded. What then could produce such a state of myocardial inefficiency over so long a period to culminate in death in heart failure? At his age one might still consider rheu-

matism, but in the absence of some evidence of valvular heart disease, much less cardiac enlargement, it would be remarkable to have extensive rheumatic myocarditis. One need not consider syphilis seriously for the Wasserman reaction was negative and there was nothing to suggest either luetic aortitis or aortic insufficiency. In the rare instance of luetic myocarditis, in the absence of aortitis and aortic insufficiency, the heart has been found much enlarged and failure rapidly progressive. The only types of myocardial disease which would explain the picture are a non-specific myocarditis—the so-called Fiedler's myocarditis, and arteriosclerotic heart disease, the latter the result of coronary arteriosclerosis and the diffuse minute scarring that may ensue.

Fiedler's myocarditis is an acute inflammation which runs its course with little or no fever, with evidences of stasis in both the greater and lesser circulations and because of its insidious nature its duration is by no means well defined. It would hardly seem reasonable that it would be so virulent as to run its course in five days, nor would it account for the increasing shortness of breath which the patient experienced over a period of four or five years. On the other hand it is not unusual in coronary arteriosclerosis without hypertension to see areas of myocardial degeneration, with fibrotic change as their sequel, which is gradual in its development and which produces a steadily lowering myocardial reserve. Under such circumstances the heart may or may not be enlarged and the slowness with which this change develops, allowing collateral circulation to come into play, is a major determining factor in the size of the heart. Such a course of events would best explain what happened in this case. This man had experienced steadily decreasing myocardial reserve as indicated by his increasing dyspnea, but he never developed frank congestive failure.

Four days before death something more acute happened, characterized by extreme dyspnea which seemed much more than mere paroxysmal

nocturnal dyspnea and suggested rather a pulmonary embolus or a myocardial infarction. There was no pain associated with this occurrence, and whereas pain is a usual accompaniment of myocardial infarction, it may be absent. Likewise, there was no specific electrocardiographic change. These are not essential and one can be led astray when one refuses to make a diagnosis

quality until they were described as "mushy." A protodiastolic gallop was present which became increasingly more pronounced. Thirty-six hours after the event he developed fever which continued, and there was some leukocytosis but the time and nature of the febrile response would be in accordance with either a myocardial infarction or a pulmonary embolism. It seems to me that

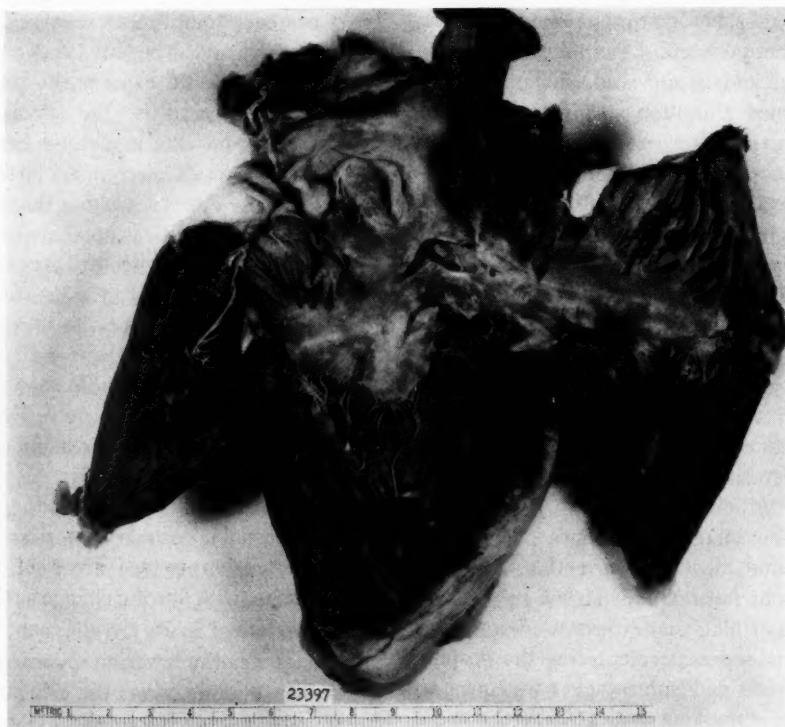


FIG. 2

of myocardial infarction in the absence of specific electrocardiographic changes. The most disturbing feature in reaching such a conclusion is the size of his heart. With it definitely enlarged this would be important, and White goes so far as to say that a very large infarct is always attended by cardiac enlargement.

In contrast, when the patient was admitted to the hospital the heart sounds were described as distant and they steadily deteriorated in

the weight of the evidence points to this patient's fundamental difficulty being myocardial rather than pulmonary and that he had coronary arteriosclerosis with diffuse fibrosis rather than a non-specific type of myocarditis, which occasioned a steadily decreasing myocardial reserve.

As a terminal event again, the weight of the evidence points to a pulmonary embolism as indicated by the sudden increase in dyspnea, the lack of pain, absence of specific electro-

cardiographic change but rather a tendency to right axis deviation, the delayed febrile response with some leukocytosis and the possible source for an embolus in a leg vein. Following this added insult, myocardial failure ensued, causing his death four days later. This would account for the pulmonary shadow in the left hilum as prominent pulmonary vessels rather than to con-

would certainly be conducive to myocardial infarction, but there is important evidence which seems to me to be lacking.

DISCUSSION

DR. BERTHRONG. Mr. Chairman, Ladies and Gentlemen: In spite of my lack of seniority before this audience and Dr. Wainwright, I must

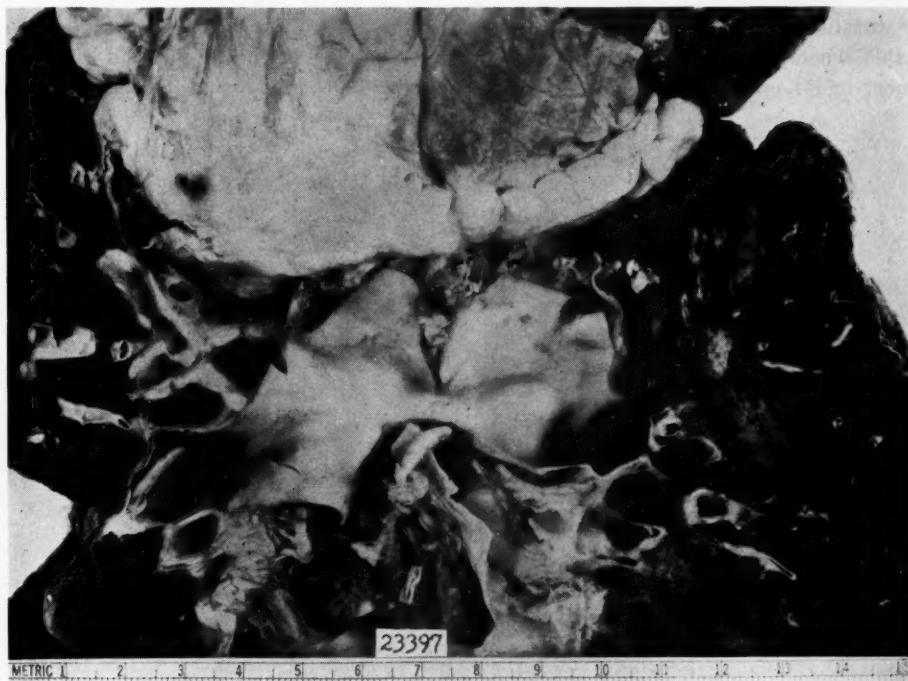


FIG. 3

sider it an unrelated pneumonia or at most tipping the balance toward failure. With such an interpretation it is not easy to explain the terminal lower abdominal pain unless it could be an embolism to an abdominal artery from a mural thrombus, for it takes but little failure for mural thrombi to form.

One cannot be too sure that he did not have a myocardial infarct but the weight of the evidence seems to me against it. For me it is difficult however to make the decision because the underlying changes thought to be present in the heart

still fulfill a role of the Pathologist which, at such a gathering, is to harass the clinician. I am sure this will be accepted without offense. Dr. Wainwright, of course I look at it in retrospect, but it seems to me as though a very prominent feature in this person's illness began as and continued to be dyspnea. This seemed to be completely out of proportion to the patient's chest signs and to his x-ray. In my recollection most patients who die with left ventricular strain such as would be produced by chronic coronary insufficiency should show more pulmonary signs,

should show rales at the base, should not show the severe dyspnea seen in this patient which was not increased by lying flat in bed. I don't recall patients with left ventricular failure exhibiting such manifestations. Would you comment on that?

DR. WAINWRIGHT: Dr. Berthrong, that is quite true, it is very difficult to explain. I think sometimes that the amount of congestion in the lung is very variable; it may be minimal and scarcely detectable whereas in other times it is very prominent and I must confess I'd be far more

showed that the right leg in the calf region and in the thighs was three to four centimeters larger than the left. I am not completely convinced that our post-mortem data show that small variations in leg circumference are significant but when it is as of great a difference as this patient exhibited, I am sure it may be of great importance. It was furthermore noted at post-mortem examination that when the prosector attempted to milk blood from the veins of the right leg, none could be obtained. Unfortunately we are not permitted to dissect the extremities



FIG. 4

happy and feel far more secure in my conclusions about this man had he definite evidences of pulmonary congestion.

DR. BERTHRONG: This is an extremely interesting case, not common but I think it is not as rare as has been noted in the past. Autopsy showed an extremely obese white man who at the time of post-mortem had intense cyanosis. This cyanosis was peculiarly noted in the face and the upper extremities and I do not have an explanation for that distribution. It was noted in Dr. Wainwright's discussion and he emphasized it in discussing the development of pulmonary emboli that one of the legs had an increased circumference. The measurement specifically

so we do not know what was in the leg veins. The heart was enlarged and weighed 450 grams. This enlargement was essentially limited to the right ventricle (Fig. 2). In the major pulmonary arteries, adherent and fresh thrombi were seen (Fig. 3). Microscopic sections showed organization of many of the large thrombi, extensive enough to suspect that the thrombi had been present for many weeks, even months (Fig. 4). Other thrombi were quite fresh and obviously had occluded the small lumina remaining after the old thrombi had organized. These fresh thrombi, whether arising in situ or as emboli, were doubtlessly the cause of the terminal episode which Dr. Wainwright correctly diagnosed.

Other sections showed smaller pulmonary arteries in the lung which contain partially organized thrombi (Fig. 5). The pulmonary parenchyma was normal except for the presence of pulmonary arteriosclerosis that is seen in so-called Ayerza's disease. It should be pointed out that these plaques of intimal proliferation were also compatible with old thrombi which had

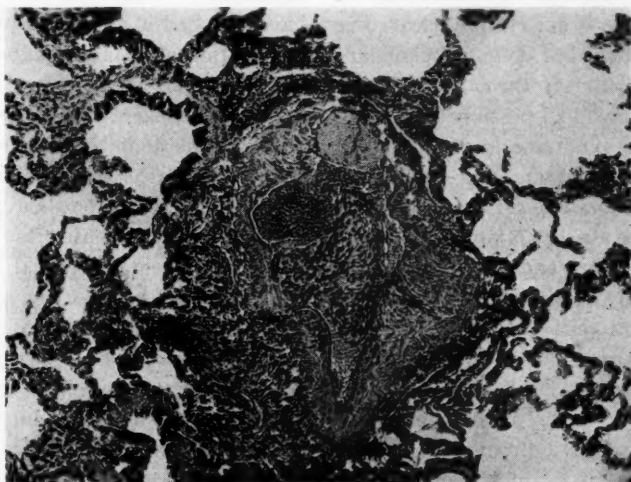


FIG. 5

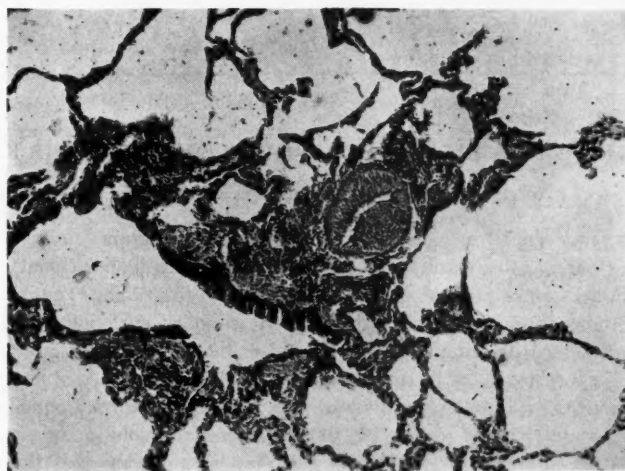


FIG. 6

considerable anthracosis and occasional small silicotic nodules. Very interestingly there were marked arteriosclerotic changes in the smaller pulmonary arteries (Fig. 6). I say "arteriosclerotic" because these were typical of the

been completely organized and recanalized to leave small crescent-shaped lumina in these terminal pulmonary arteries.

We now can postulate that this patient for some unknown reason began to develop pulmo-

nary embolization or thrombosis four or five months ago, which partially occluded his major pulmonary arteries. Smaller emboli occurred in smaller pulmonary vessels. Why he did not exhibit more of the clinical manifestations of chronic cor pulmonale is not entirely clear. The relationship of the mild but definite pulmonary silicosis to these pulmonary thrombi cannot be clearly stated. We have had possibly ten autopsies of cases of this syndrome in the past few years. It is becoming of increasing importance to recognize this peculiar clinical combination of severe dyspnea in the absence of prominent chest signs and often with cough and often with prominent hilar shadows by x-ray which I think must represent dilated major pulmonary vessels proximal to the thrombi or even the vessels enlarged by the thrombi. All of the patients have not manifested an absence of orthopnea but others have shown it as a prominent feature. Some of the patients are cyanotic, which is not always easily explained. In this patient I think

it is perfectly clear that as the right atrial pressure rose, there was an anatomical patency of the foramen ovale allowing a shunt of blood across from right to left and providing an easy explanation for the cyanosis. All of the patients have not had a patent foramen ovale and the explanation of cyanosis is then not understood. The thrombus material has been found in the major pulmonary arteries in all of our cases which has led to incomplete occlusion or stenosis of the major arteries. Since death did not occur immediately, symptoms developed later when the pulmonary stenosis resulted in right ventricular strain and eventual failure. The origin of the emboli has occasionally been found in the leg veins but in others, as in this case, no source for emboli or etiology for thrombosis has been discovered. Since left ventricular failure has usually not been present in these cases, pulmonary infarcts have not been seen.

1. CARROLL, D., Chronic Obstruction of Major Pulmonary Arteries, *Am. J. Med.*, 1950: 9: 175

ARMED FORCES DISCOUNT REPORTS ON HEPATITIS RATE

THE AMA WASHINGTON LETTER NO. 7, FEBRUARY 13, 1953

Following press reports of high incidence of homologous serum jaundice (hepatitis) among U. S. troops getting plasma, the Armed Forces Medical Policy Council and Army Surgeon General's office decided the record should be set straight. These points were made: (a) Studies show that 23% of the severely wounded receiving 5 to 10 units of plasma contract hepatitis from 60 to 180 days after the infusions, but mortality rate is only one in 1,000 cases, (b) while serum albumin has been found free of hepatitis virus, there isn't enough supply to replace plasma, (c) a National Research Council committee is working on sterilization of plasma but until it arrives at a solution, plasma will continue to be used by the services. Officials said they were anxious that the public not stop donating blood because of the misinformation on plasma.

Component Medical Societies

ALLEGANY-GARRETT COUNTY

LESLIE E. DAUGHERTY, M.D.

Journal Representative

The Allegany County school health program is being expanded, due to the addition of Dr. Ralph Reiter, local physician, to the health staff on a half-time basis. Dr. Reiter will give physical examinations to students who need medical attention, but who have not had help because their parents were unable to afford it. On completing examinations if medical attention is needed, the child will be referred to a private physician, or one of the many special clinics offered by the Health Department. Dr. Reiter has been busy with immunization work in the schools during the past 3 months.

Dr. W. Royce Hodges, local obstetrician spoke before the Allegany County lay health group, February 17, in the Union St. Building.

The following is quoted from the Cumberland Sunday Times:

"Dr. Winthrop Phelps, Baltimore, a world famous leader in the treatment of cerebral palsy, checked the condition of more than 80 children who appeared at the clinic conducted by the League for Crippled Children, City Hall Square. Seven of the patients were from Garrett County. The League brings leading specialists for clinics here in the fields of infantile paralysis, spastic afflictions, cerebral palsy, orthopedic ailments, children's abnormalities and related handicaps. The next clinic will be conducted by Dr. David Weinberg, Baltimore, in March, for orthopedic cases."

"Dr. E. Don Taylor, 73, well-known physician at Lonaconing since 1921, died on February 10, 1953, at the Memorial Hospital.

"In May of this year Dr. Taylor would have completed 50 years as a practicing physician. He had been in ill health a number of years. He was a native of Downs, Kansas, and came from a family of physicians. His father and grandfather both were doctors. During his childhood he moved to Moline, Ill. In 1903 Dr. Taylor graduated from Hahnemann Medical College in Chicago. He was a practicing

physician following graduation at East Moline, Ill., where he also served for a time as mayor. On March 15, 1910 he married Miss Katherine Swanson, of Moline, who survives. During World War I, Dr. Taylor served in the Medical Corps and in 1919 he came to Lonaconing during the influenza epidemic. In 1921 he returned to Illinois, later moved his family to Lonaconing and had maintained his office and residence since at 15 Douglas Avenue.

"Dr. Taylor was active in a number of organizations. He was a member of the Lions Club of Lonaconing; had been a director of the Lonaconing Savings Bank; Allegany-Garrett Medical Association; Georges Creek Valley Lodge 181, AF & AM; Scottish Rites Consistory; Ali Ghan Shrine Country Club, Royal Order of Jesters, and Lodge 470, BPO Elks, Frostburg. American Medical Association; Moline, Ill., Masonic Lodge; and James P. Love Post 92, American Legion, Lonaconing.

"Surviving besides his wife are a daughter, Mrs. Joseph Reese, at home and a brother, R. Mac Taylor, Berlin, Pa."

BALTIMORE CITY MEDICAL SOCIETY

CONRAD ACTON, M.D.

Journal Representative

More members of the Society are coming to meetings. The upswing in attendance follows the pace of the scientific programs started last year. The Program Committee has raised the average audience from about fifty (generous) to the neighborhood of two hundred (conservative) in one short year. The February symposium on diabetes was no exception, the Hall was packed. Perhaps the questions were fewer than at some meetings, this was due more to the thoroughness of the coverage than any lack of interest.

The testimonial to GUS, given full coverage elsewhere in this Issue, was a surprise to most of us. It lifted the curtain for the nostalgic past for a few moments.

Coffee and doughnuts—courtesy the Auxiliary—after the Meetings is catching on. In January the

Ladies set up their stand in a side room and were inconspicuous, and perhaps not overly patronized. In February the table was in the main right-of-way and did a land office business. Eased the check-room jam a lot, too.

The report of the Committee on Blue Shield payments to Hospitals has brought no further action. The thorough investigation of Dr. Ed Jarrett and his committee was fully discussed in the January Meeting. President Fort's summary of the Society's attitude seems to have hit the nail on the head: Trust has to start somewhere with somebody and, as long as the responsibility for these sums is kept with the *professional* staffs of the hospitals, the Medical Society can do no more. Responsibility lies then with the doctors to see that their hospitals do not practice medicine in competition with their own visiting staffs.

Revision of the Constitution of the City Society has progressed from the committee stage to legal review. It will be sent to each member for 'committee-of-the-whole' action. Each of us is expected to read and find mistakes. Any real errors should be corrected before passage, amendments later are to be avoided. Errors found, or desired changes, should be called to the attention of the Committee in advance of discussion on the floor, if possible.

The Course in Electrocardiography under the auspices of the City Society began on schedule Tuesday, February 24. Meetings are held in the Auditorium of the Nurses Home of the Union Memorial Hospital. The first two meetings have been very well attended. The decision of Dr. Whitehouse to make annual Staff instruction lectures open to the members of the Society seems to have been a very happy one.

BALTIMORE COUNTY MEDICAL ASSOCIATION INC.

DONALD L. SOMERVILLE, M.D.

Journal Representative

The Baltimore County Medical Association has now completed its proceedings for incorporation, thanks in large part to the efforts of its legal advisor, Mr. William Wells. It seems apt to publish the legal document *in toto* for the enlightenment and guidance

of other Medical Societies which might wish to follow a similar course of action. The Baltimore County Association is satisfied that this is a wise thing for many reasons, previously discussed in these pages.

The following is a copy of the Act of Incorporation:

BALTIMORE COUNTY MEDICAL ASSOCIATION INC.

Articles of Incorporation

FIRST: WE, THE UNDERSIGNED, Charles H. Williams, M.D. whose post office address is No. 1632 Reisters-town Road, Pikesville 8, Maryland, Charles F. O'Donnell, M.D., whose post office address is No. 7501 York Road, Towson 4, Maryland, and Thomas E. Wheeler, M.D., whose post office address is corner Liberty and Clifmar Roads, Randallstown, Maryland, each being at least twenty-one years of age, do hereby associate ourselves as incorporators with the intention of forming a corporation under and by virtue of the General Laws of the State of Maryland.

SECOND: The name of the corporation (which is hereinafter called the Corporation) is BALTIMORE COUNTY MEDICAL ASSOCIATION INC.

THIRD: The purposes for which the Corporation is formed are as follows:

1. To bring into one organization the physicians of Baltimore County; so that by frequent meetings and full and frank interchange of views they may secure such intelligent unity and harmony in every phase of their labor as will elevate and make effective the opinions of the profession in all scientific, legislative, public health, material and social affairs, to the end that the profession may receive that respect and support within its own ranks, and from the community, to which its honorable history and great achievements entitle it; for fostering a fraternal feeling among its members and promoting their ethical relations, and to do the things that stand for the benefit of the civic body and the advancement of the medical profession.

2. To acquire, own and hold such real and personal property as may be necessary and convenient for the transaction of its business and in furtherance of its purposes, and to sell, lease, encumber, mortgage, transfer, rent, and otherwise deal with or dispose of real and personal property as may from time to time be or become necessary in the conduct of its business.

3. To apply for, obtain, register, purchase, lease or otherwise to acquire, and to hold, use own, operate and introduce, and to sell, assign or otherwise dispose of, any trade-marks, trade-names, copyrights, patents, inventions, improvements, and secret process used in connection with or secured under letters patent of the United States, or elsewhere, or otherwise, and to use, exercise, develop, grant licenses in respect of, or otherwise turn to account any such trade-marks, copyrights, patents, licenses, processes and the like, or any such property or rights, necessary and incidental to these purposes.

4. To acquire all necessary franchises, licenses, grants,

permits and other evidences of authority to carry on said business and to sell, transfer, assign or dispose of, in the manner allowed and provided by law, said franchises, licenses, grants, permits or other evidences of authority to carry on said business.

5. The Corporation shall have no capital stock and whatever profits shall accrue to the corporation shall be used for the promotion of the general good and welfare of its members and for the furtherance of its business.

6. The foregoing clauses shall be construed as both purposes and powers and the matters expressed in each clause shall, except as otherwise expressly provided, be in no wise limited by reference to or inference from the terms of any other clause, but shall be regarded as independent purposes and powers and the enumeration of specific purposes and powers shall not be construed to limit or restrict in any manner the meaning of general terms of the general powers of the corporation, nor shall the expression of one thing be deemed to exclude another, although it be of like nature, not expressed.

7. The above granted powers to the corporation are in furtherance and not in limitation of the general powers conferred by law upon corporations.

FOURTH: The post office address of the principal office of the Corporation in this State is No. 1211 Cathedral Street, Baltimore, Maryland. The name and post office address of the resident agent of the Corporation in this State are, William D. Wells, 605 Reisterstown Road, Pikesville 8, Maryland. Said resident agent is an individual actually residing in this State.

FIFTH: The number of directors of the Corporation shall be seven (7), which number may be increased or decreased pursuant to the by-laws of the Corporation, but shall never be less than three; and the names of the directors who shall act until the first annual meeting or until their successors are duly chosen and qualify are: Charles H. Williams, Charles F. O'Donnell, Thomas E. Wheeler, David H. Andrew, James G. Howell, Melvin E. Davis, and Wilmer K. Gallagher.

SIXTH: The duration of the Corporation shall be perpetual.

IN WITNESS WHEREOF, we have signed these Articles of Incorporation on this day of , 1952.

Witness as to all

.....
Charles H. Williams

.....
Charles F. O'Donnell

.....
Thomas E. Wheeler

STATE OF MARYLAND: BALTIMORE COUNTY, TO WIT:

I HEREBY CERTIFY that on this day of , 1952 before me, the subscriber, a notary public of the State of Maryland in and for the County of Baltimore personally appeared Charles H. Williams, Charles F. O'Donnell and

Thomas E. Wheeler and severally acknowledged the foregoing Articles of Incorporation to be their act.

WITNESS my hand and notarial seal, the day and year last above written.

.....
Notary Public.

WASHINGTON COUNTY MEDICAL SOCIETY

O. D. SPRECHER, M.D.

Journal Representative

VICTOR D. MILLER, M.D.

The Washington County Medical Society is proud of its gold star member, Dr. Victor D. Miller, 131 W. Washington Street, Hagerstown, Maryland. Dr. Miller was born in Washington County on March 15, 1876. His secondary education was accomplished at the Mercersburg Academy and Princeton University. He was graduated from the medical school of the University of Pennsylvania in 1900, and is a member of the Phi Alpha Sigma medical fraternity. His internship was served from 1900 to 1901 in the Germantown Hospital, Philadelphia, Pennsylvania and Kings County Hospital, New York.

He began the practice in medicine in Hagerstown in 1901, and is still active. He has been a member of the medical staff of the Washington County Hospital since 1905, and served as President of that organization. He has been a member of the American Medical Association, Washington County Medical Society, Cumberland Valley Medical Association, and the Medical and Chirurgical Faculty of the State of Maryland since 1903.

Dr. Miller has always been an active participant in community affairs. Among these are the following: Member of the 1st board of directors of the Hagerstown Y.M.C.A., President of the Washington County Chapter of the American Red Cross, Public Health Association, Chamber of Commerce, Rotary Club, and Fountain Head Country Club. During both World Wars he served on the Medical Advisory Committee of the local draftboard.

It is indeed a pleasure to congratulate Dr. Miller on achieving 50 years of service in the Medical Society.

QUARTERLY MEETING

The first regular quarterly meeting of the Washington County Medical Society was held at the Alexander Hotel, Hagerstown, Md., Thursday evening, January 29th, at 6:00 P.M.

The principal speaker was Samuel P. Asper, Jr., M.D., Johns Hopkins Hospital, Baltimore, Maryland, whose subject was: The newer aspects of the Treatment of Thyroid Disease.

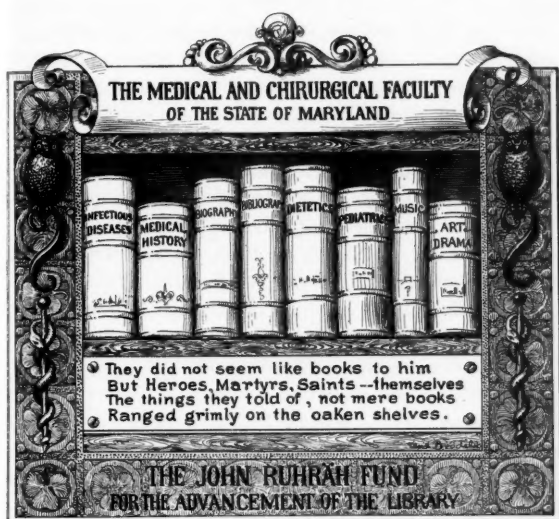
W. Ross Cameron, M.D., recently re-appointed Health Officer of Washington County, spoke briefly concerning his recent tour of duty with the Medical Advisory Committee of the U. S. Army serving with the Nationalist Chinese Forces on the island of Formosa, his pleasure on returning to his present occupation and location, and the mild sporadic epidemic of infectious hepatitis in nearby Frederick County.

**DEFENSE DEPARTMENT PROPOSES REGROUPINGS
IN DOCTOR DRAFT****THE AMA WASHINGTON LETTER NO. 7, FEBRUARY 13, 1953**

1. All registrants except those in the present Priorities I and II to be divided into two groups. *First* to be taken, those with no military service, who would be inducted by age, with the youngest going first. *Next*, those who have had active duty, with those having the least active duty inducted first. (Those remaining in the present Priorities I and II to be called immediately on expiration of deferrals.)
2. Maximum age for inductions would be maintained at 51. (A lower maximum had been discussed informally.)
3. Men called to duty as reservists would be commissioned in grades "commensurate with professional education, experience or ability;" in other words, current arbitrary limitations on numbers of higher commissions would be waived in case of medical officers.
4. Other provisions—law to expire July 1, 1955; National and State Advisory Committees continued and strengthened; World War II service with cobelligerents recognized for purposes of Doctor Draft; \$100 special pay not disturbed. Reserve commissions would terminate upon completion of stipulated active service.

Library

THE JOHN RUHRÄH FUND



Dr. John Ruhräh, a world-renowned pediatrician, a world traveler and a profound scholar, was born on September 26, 1872, at Chillicothe, Ohio. He was the son of Daniel Conrad and Mary Fincknauer Ruhräh. The unusual family name was traced to an abbreviation of Ruhrahn, indicating that the first of that name came from the Ruhr Valley. His father was a native of Bremen, Germany. His maternal grandparents were Baltimoreans and so it was to this city that he came to complete his education.

In 1894, he received his degree of Doctor of Medicine from the College of Physicians & Surgeons of Baltimore and joined the staff of Mercy Hospital, where he served as Resident Physician until 1897. He then went abroad to study at the Pasteur Institute in Paris. Returning to Baltimore, he spent a year as Physician-in-Charge of the Pasteur Department of the College of Physicians & Surgeons. Then, he became the Quarantine Physician of the Port of Baltimore, serving until 1900, when he returned to Europe for postgraduate work at the universities of Berlin, Vienna, Paris and London.

Entering private practice in Baltimore in 1901, he maintained his academic connection with the College of Physicians & Surgeons. After the merger with the University of Maryland Medical School, he joined the faculty as Professor of Diseases of Children.

As a member of the Medical and Chirurgical Faculty, he served as Secretary from 1907 to 1917, as President in 1919; and, later, as Chairman of the Library Committee.

His Presidential Address to the Faculty on April 22, 1918, was on the subject of the medical library. Not only did Dr. Ruhräh review the history of the library but he also stressed the value of a medical library to the physician, the outlook for its future and the hope of every scholar that the library will rightfully take its place as an important school where one can commune

with the old and new masters. He made a plea to the members not to let history repeat its past errors and let the fate of the Faculty in 1860 be a warning for all to hold the torch on high. He counseled his listeners to remember that "we can only give the profession the opportunity to use the splendid collection of books at their disposal. We cannot drive them to the Pierian spring, much less make them drink deeply of it; but those of us who have labored in the interest of the Library, and of medical libraries in general, at least have the great satisfaction of knowing that we have paved the way for the profession, and if they persist in straying in the bypaths, instead of on the broad highway of knowledge, we can only point again and again at the sign board with the finger pointed to SUCCESS. For it means success to be well informed. Look about at the most successful medical men, successful in the real sense of the word, and you at once see that they are successful because they know."

Dr. Ruhräh was as much at home in the printed world as in the field of medicine for he was not

only interested in medical books but also had a wide knowledge of books. His bookshelves in his home were filled to capacity with first editions, language dictionaries, volumes of verse, essays and philosophy. Many were in German, Spanish, French and Italian. One of his greatest sources of pleasure was that which he found in his complete set of the *Oxford English Dictionary*. He often said that the only thing he feared was that he would not live long enough to learn what was in those twenty volumes. Another favorite book was Pepys' *Diary*, which he recommended to those who talked about hard times. His copy of Stevenson's *Home Book of Verse* was always at hand. He had memorized the famous children poems and delighted in recalling them.

Dr. Ruhräh not only found interest in his profession and the literary world but also in the letters, music, drama and painting. He had a standing order for seats for every worthwhile event at the Lyric and he seldom missed an important first night at the theatres. He planned his annual trips abroad so that they would include one or more of the summer music festivals. He lived modestly but his adventures in eating led him from restaurant to restaurant in every corner of the world. Explaining his adventures in Baltimore, he replied that he was searching for some restaurant which supplied food as good as Baltimore used to boast; but he was never able to find that paradise.

Dr. Ruhräh had a bedside manner that came from long experience. It was fortified by study, understanding and a personal interest in his patients. He was a great diagnostician. In successfully treating a case, it has been said that he cured the child as well as the parents by instilling confidence in the bewildered and frightened parents, who borrowed strength and courage from him in their time of need.

Dr. William Osler regarded him to be one of the most brilliant of the younger men and showed him the way to the heights. This great inspiration was with Dr. Ruhräh to the end. It interested him in the history of medicine and opened the doors of the libraries of the world. It gave him an incentive to write and his writings were in constant demand. Dr. Ruhräh was a fluent writer. He edited two volumes: "Pediatrics of the Past, An Anthology," which is a source book of unusual interest and merit,

and "William Cadoza: His Essay on Gout." With Dr. Julius Friedenwald, he collaborated in writing "Diet in Health and Disease" and "Dietetics for Nurses." Alone, he wrote a "Manual of Diseases of Infants and Children." With Dr. E. E. Mayer, he wrote "Poliomyelitis," which is regarded to be one of the standard treatises on the disease. In addition to these medical writings, he was a frequent contributor to the *Sunpapers*, reviewing books and plays, writing feature articles and poetry and criticizing musical programs.

Dr. Ruhräh was interested in anything that was worthwhile. He admired knowledge but preferred practicability. In his estimation, ability and common sense were the most valuable gifts of man.

While in Naples in 1930, he was stricken with poliomyelitis, a disease which seriously damaged his body but left his mind untouched. Although he was alone in a strange land and paralyzed, he started taking lessons in Italian from his native nurse as soon as he recovered his speech. Before he came home, he was reading Dante in the original. During his stay in the hospital, he studied Russian, advanced Spanish and reviewed his Latin. Upon his return home, he entered Mercy Hospital and later went to Warm Springs, Georgia, where he responded to treatment. His determination to get well and his ready wit were always with him. Much to the astonishment of his associates, he assumed his professional duties, his literary activities and interest in the municipal affairs of Baltimore.

In October of 1934, he went to Texas with the intention of going to Mexico for sightseeing and studying conditions from every angle but illness prevented him from carrying out his plans. Returning to Baltimore, his death occurred on March 10, 1935.

According to his will, Dr. Ruhräh left most of his library to the Medical and Chirurgical Faculty. As a tribute to his loyal devotion to the Faculty and the wish to preserve his heritage, the John Ruhräh Memorial Room was dedicated on April 29, 1936. This Room houses the cultural books from Dr. Ruhräh's library, which he bequeathed to the Faculty. In addition to his library, Dr. Ruhräh left his estate to relatives but with the provision that its residue will go to the Faculty on the death of the legatees. Upon the death of one of the beneficiaries,

the Faculty received one-third of the corpus of the estate, and the balance of two-thirds will be received after the other two beneficiaries die. He further directed that the Library Committee of the Faculty shall have control of the income to be used as directed by the will so that "the Library needs be considered first of all."

The Ruhräh Fund bookplate was designed by Max Brödel, who followed the instructions which Dr. Ruhräh left in a letter addressed to the Faculty. He directed that the design suggest a row of books on a shelf with each book bearing the title of the subjects in which he had been particularly interested.

"Rich as was this man's life, it was far too short

for all the things his great spirit had to do."—
Editorial—*Morning Sun*—March 11, 1935.

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HAVE YOU PAID YOUR AMERICAN MEDICAL ASSOCIATION DUES?

The American Medical Association Annual Session will be held in New York City from June 1 to June 5, 1953. The headquarters, Scientific and Technical Exhibits, and other meetings will be at the Grand Central Palace, 44th and Lexington Avenues.

To avoid the usual congestion at the registration windows and to save yourself trouble and delay, the American Medical Association is issuing advance-registration cards which will make it possible to quickly register instead of waiting in line to have your record checked with the membership roster.

To register it is necessary for you to have a pocket card showing your membership dues in the American Medical Association paid for 1953.

If you have not already sent in your check to cover 1953, we suggest that you do so at once, so as to give us an opportunity to forward the payment to the A.M.A. in time to have the A.M.A. issue a pocket card and also an advance-registration card to you.

STATE OF MARYLAND DEPARTMENT OF HEALTH
MONTHLY COMMUNICABLE DISEASE REPORT

Case Reports Received during 4-week Period, February 27-March 26, 1953

	CHICKENPOX	DIPHTHERIA	GERMAN MEASLES	HEPATITIS, INFECT.	MEASLES	MENINGITIS, MENINGOCOCCAL	MUMPS	POLYOMYELITIS, PARALYTIC	ROCKY MT. SPOTTED FEVER	STEEPLE-SORE THROAT INCL. SCARLET FEVER	TYPHOID FEVER	UNDULANT FEVER	WHOOPING COUGH	TUBERCULOSIS, RESPIRATORY	SYPHILIS, PRIMARY AND SECONDARY	GONORRHEA	OTHER DISEASES	DEATHS Influenza and pneumonia
Total, 4 weeks																		
Local areas																		
Baltimore County.....	94	—	8	4	4	—	23	—	—	118	—	—	2	19	1	11	—	3
Anne Arundel.....	18	—	2	1	7	—	7	—	—	15	—	—	—	1	—	3	—	7
Howard.....	1	—	—	—	2	—	—	—	—	1	—	—	1	—	—	—	—	—
Harford.....	12	—	69	3	2	—	4	—	—	6	—	—	—	2	—	2	m-1	—
Carroll.....	6	—	—	7	4	—	—	—	—	—	—	—	—	4	—	—	—	1
Frederick.....	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	3	—	2
Washington.....	—	—	—	—	—	—	—	—	—	—	—	—	—	6	—	3	—	1
Allegany.....	8	—	—	4	10	1	1	—	—	4	—	—	—	6	—	1	—	2
Garrett.....	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1	—	—	2
Montgomery.....	43	—	11	1	10	3	22	—	—	11	—	—	—	13	—	5	—	3
Pr. George's.....	28	—	3	6	8	—	20	—	—	11	—	—	—	11	—	2	—	2
Calvert.....	—	—	—	—	1	—	1	—	—	—	—	—	—	1	—	—	—	—
Charles.....	—	—	—	—	—	—	1	—	—	—	—	—	—	1	—	—	—	—
Saint Mary's.....	1	—	—	3	—	—	—	—	—	—	—	—	—	—	—	2	—	1
Cecil.....	—	—	—	—	—	—	—	—	—	1	—	—	—	—	—	1	—	—
Kent.....	16	—	136	—	10	—	6	—	—	44	—	—	—	—	—	—	—	—
Queen Anne's.....	—	—	1	—	4	1	1	—	—	4	—	—	—	1	2	—	—	2
Caroline.....	—	—	—	—	—	—	2	—	—	2	—	—	—	3	—	5	—	—
Talbot.....	1	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	3
Dorchester.....	6	—	—	—	1	—	5	—	—	—	—	—	1	2	—	6	—	—
Wicomico.....	11	—	1	—	—	—	—	—	—	1	—	—	—	4	—	8	r-1	—
Worcester.....	2	—	—	—	—	—	—	—	—	—	—	—	—	3	1	—	r-6	1
Somerset.....	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	2
Total Counties.....	247	0	231	29	63	5	93	0	0	218	0	0	4	77	5	52	—	32
Baltimore City.....	246	0	85	2	44	3	143	0	0	244	1	0	12	99	8	497	—	32
State																		
Feb. 27-Mar. 26, 1953.....	493	0	316	31	107	8	236	0	0	462	1	0	16	176	13	549	—	64
Same period 1952.....	412	1	209	16	1890	13	105	1	0	163	0	0	8	250	7	487	—	126
5-year median.....	561	10	83	—	590	12	243	0	0	167	2	5	55	223	90	502	—	87
Cumulative totals																		
State																		
Year 1953 to date.....	1537	6	499	119	240	36	470	2	0	992	3	2	60	583	38	1793	—	331
Same period 1952.....	1271	4	277	83	5803	29	380	6	0	433	6	8	47	658	33	1470	—	244
5-year median.....	1427	28	133	—	1270	31	600	1	0	450	4	13	213	606	261	1575	—	235

m = malaria reported by Aberdeen Proving Grounds, origin in Korea, home residence not stated.

r = positive rabies in animals.

Streptococcal infections: There has been a marked rise in the number of reported cases during the month of March. PREVENT RHEUMATIC FEVER!

BLUE CROSS AND BLUE SHIELD

MARYLAND HOSPITAL SERVICE, INC.

R. H. DABNEY*

Maryland Hospital Service set new records in 1952—a new high mark in enrollment, in subscription income, in patients hospitalized and in payment to member hospitals. Despite this growth, the Plan operated at a loss for the second year in a row, and had to draw substantially on its subscriber reserves to meet expenses. This experience was typical of many Blue Cross Plans in 1952; and explains why we and others have had to increase subscription charges.

There are several apparent reasons for this. Hospital costs have continued upward; more subscribers are using more care; and operating costs have increased slightly. But there are hidden reasons too—reasons more basic, more fundamental, and not so easily understood.

Just what is Blue Cross? It is a non-profit voluntary prepayment program to provide health services to the self-supporting population in our community. Stated another way, Blue Cross is a means of removing the financial barriers to health services, organized and sponsored by the suppliers of those health services—the hospitals and the doctors.

Blue Cross is not an insurance company. It operates on many of the time-tested insurance principles, but at the same time disregards others in attempting to provide a service to the entire community, not to just a selected segment of the community. Unlike commercial insurance companies, we take small groups and big; we don't ferret our bad risks by health statements; we charge all groups the same premium regardless of size, type of industry, sex or age of employees—a community rate if you will; we permit continued coverage after leaving an employed group, including retired persons; we don't cancel groups or individuals who are bad risks.

Blue Cross is expected to provide a service to the whole community—that is why it is given a preferred

status as a non-profit, tax-free corporation. But is it attempting the impossible in providing a social need and not adhering completely to sound insurance practice?

I don't profess to know the final answer, but I am willing to believe that it can be done, that Blue Cross can move ahead and fulfill its stated community function successfully. But it can be done only if all are willing to bend every effort to make it work.

First, we must intensify our enrollment efforts to produce better selection and better operating experience. I believe we need to spend more money and effort on sales promotion and public education—particularly the latter; to stimulate a wave of public support, support from management and labor as well as the individual subscriber. This can only be done with strong backing from hospitals and from the medical profession.

Secondly, we must have complete cooperation and support from the hospitals and the doctors in conserving Blue Cross resources through the control of costs and the elimination of unnecessary hospital admissions and services. Particularly, the medical profession must understand its basic relationship and responsibility to Blue Cross; *they must understand that the whole economy of our operation is a matter of individual doctor determination.* They must understand that because of the "nature of our beast," an extra day's stay, an additional admission which could be treated outside a hospital, one extra laboratory test or an additional drug administration, may spell the end of our ability to provide a service to the community—and may bring on the socialization of health services. And these controls toward conservation of resources, cannot be achieved by regulation from our office. The responsibility must be placed squarely on the treating physician—and on the hospital. All Blue Cross can do is widen the understanding of the problem.

Finally, Blue Cross, the hospitals and the phy-

*Resume of Report by R. H. Dabney, Director of Maryland Hospital Service, Inc., at the Annual Meeting of Corporation, January 27, 1953.

sicians together, must educate the public to spend an increasing proportion of their total income for health services. That hospital and medical costs have risen substantially over the past 10 years, no one will deny; but they have not risen out of proportion to the value of other services and commodities, and the quality of care has improved vastly. I frankly see little hope for a change in the upward trend of hospital costs.

Blue Cross has met a real public need in the past 15 years, as any of its 43 million subscribers in the nation will testify. Its job has become more complex with its growth and major problems need to be solved. The future requires careful and thoughtful planning and direction, but most of all, understanding and teamwork on the part of all concerned. I believe it can move ahead—and I hope you agree with me.

BALTIMORE CHAPTER: THE AMERICAN RED CROSS

The Baltimore Chapter, American Red Cross, is in need of part time physicians, to be paid on a per diem basis, to cover blood donor operations at odd hours. If interested please contact Dr. Hernandez, Medical Director, HOPkins 9905, or by letter—Baltimore Chapter, American Red Cross, St. Paul and Twenty-third Streets.

ODM TO HANDLE GAMMA GLOBULIN DISTRIBUTION

THE AMA WASHINGTON LETTER NO. 7, FEBRUARY 13, 1953

The Office of Defense Mobilization has taken over responsibility for distribution of gamma globulin for use in treatment of paralytic poliomyelitis, infectious hepatitis and measles. Details of distribution are being evolved by a National Research Council committee of physicians. It is understood the plan contemplates distribution of the central supply of gamma globulin to State Health Officers, who will be responsible for its final local use.

POSITION AVAILABLE

There will be an examination for the opening for Chief Medical Director of the Board of Education of the City of New York. Fifteen hours of service per week. Maximum age—50 years.

For details write to Jacob Greenberg, Associate Superintendent, Board of Education of the City of New York, 110 Livingston Street, Brooklyn 2, New York.

Ancillary News

NURSING SECTION

M. RUTH MOUBRAY, R.N., *Executive Secretary,*
Maryland State Nurses Association

Journal Representative

MARYLAND STATE BOARD OF EXAMINERS OF NURSES
REPORT TO THE MARYLAND STATE NURSES'
ASSOCIATION FOR THE YEAR 1952

We are submitting the following report of the major activities of the Maryland State Board of Examiners of Nurses during 1952.

Four basic collegiate programs in nursing have opened in Maryland at:

Washington Missionary College	Takoma Park
St. Joseph College	Emmitsburg
Mount St. Agnes College	Baltimore
University of Maryland	

These are all 4 year programs. Degrees in nursing will be granted by the colleges. The patterns are all different and will not be described in this report.

Including these, there are now 24 basic collegiate and hospital programs in nursing in Maryland. The University of Maryland offers both the basic collegiate (4 year program) and the hospital program (3 years).

A more liberal interpretation by the Attorney General of the section in the law relating to nursing makes it possible for students to receive more credit in time in a 3 year program (required by the law) for college work.

The colleges in turn agreed to accept approved nursing practice in hospitals and other health agencies towards requirements for their degrees. In general these were the fundamental adjustments it was necessary to make in order for the Board of Examiners to be able to approve the programs and accept the graduates for licensure as registered nurses.

During the year the Board has approved affiliations in Tuberculosis Nursing at the Baltimore City Hospitals and in Psychiatric Nursing at the Spring Grove State Hospital.

The Board of Examiners cooperated with the National Nursing Accrediting Service. The programs in all the schools of nursing in Maryland in 1951 that had not been fully accredited were reviewed by the National Nursing Accrediting Service.

There were 21 schools in Maryland in 1951—

4 had been fully accredited previously

15 were temporarily accredited in 1952

The goal is full accreditation of all the programs within a 5 year period.

At the request of the Board of Examiners of Nurses, the Maryland League for Nursing made recommendations to the Board relating to the programs in schools of nursing. The study of the recommendations by the Board has been completed and the material is in the hands of the printer. The Board appreciated the cooperation and suggestions of the League and the members of the various committees who contributed so helpfully to this project.

The terms of two Board members, Mrs. Dorothy F. McBride, President, and Sister Mary Vincent Dunnigan, Secretary-Treasurer, expired in May 1952. The Board regretted that neither member felt it was possible to continue. We welcome the two new members, Mrs. Bessie W. Parr, Educational Director, Maryland General Hospital School of Nursing, and Sister Katherine Marie Sump, Nursing Arts Instructor, St. Joseph's Hospital School of Nursing. Mrs. Elizabeth F. Norwood was elected President and Miss Irene M. Duffy, Secretary-Treasurer.

Standard Scores are now used in reporting State Board examination results. Information concerning the scoring and reporting of State Board Examinations was sent to the schools of nursing.

Following a study of scores and failures in the six subjects, the Maryland Board of Examiners decided

to set the standard score 350 as passing in each subject. The studies indicated that this will mean a slight advantage to candidates.

This use of 350 passing score may facilitate interstate registration when it becomes possible for more states to use this passing score. It also enables the Board to use the new plan of the Test Pool Committee for reporting scores to candidates and schools. This will eliminate a great amount of clerical work in the Board office which in turn will mean more prompt reports to candidates and will speed up the process of registration.

During 1952, State Board Test Pool examinations have been used for Licensed Practical Nurse examinations. Beginning in January 1953, all candidates for licensure as Licensed Practical Nurse must meet requirements in the curriculum issued by the Board of Examiners for Licensed Practical Nurse schools (1950) except the practice in Obstetric Nursing.

There are now 9 approved schools for practical nurses in Maryland:

Baltimore City Hospitals	Baltimore
South Baltimore General Hospital	Baltimore
Cambridge-Maryland Hospital	Cambridge
Eastern Shore State Hospital	Cambridge
(Classes have not started)	
Henryton State Hospital	Henryton
Rosewood State Training School	Owings Mills
Victor Cullen State Hospital	Sanatorium
Crownsville State Hospital	Crownsville
Springfield State Hospital	Sykesville

The school at the Home for Incurables, Baltimore, Md., closed September 1952.

A re-interpretation of the provision in the law relating to credit in time in the 3 year course in nursing was made by the Attorney General.

Credit in time up to 8 months in the 3 year course may be granted by the school of nursing to a licensed practical nurse who has graduated from a school of practical nursing that is approved by the Board of Examiners of Nurses in the state where the school is located or by the National Association for Practical Nurse Education. No course credits for the practical nurse program would be granted. The student would complete the courses of instruction and weeks of experience in the various services required for registration as a graduate nurse and be granted credit in

time at the end of her program. All decisions about admission of the students, the details of their program and the amount of credit in time are to be made by the school of nursing.

The total number of Maryland Registered Nurses to date (1904 to Dec. 31, 1952) inclusive, is 21,294.

The total number of graduate nurses registered from January 1, 1952, to December 31, 1952, is 1,203. Of this number 857 were registered with examination and 346 by Inter-state Registration. Note: 372 of the Passed Candidates of the October 1951 Examination were not registered until January 23, 1952.

There have been three (3) regular examinations for State registration in the year 1952 with the total enrollment of first examination candidates—568 and re-examination candidates—180 (the combined total of 748).

April 15-16, 1952 (Osler Hall, 1211 Cathedral Street, Baltimore, Md.)

		Passed	Failed	Absent
1st exam. candidates.	82	60	20	2
re-exam. candidates.	89	50	37	2
	171	110	57	4

June 24-25, 1952 (Osler Hall, 1211 Cathedral Street, Baltimore, Md.)

		Passed	Failed	Absent
1st exam. candidates.	73	66	6	1
re-exam. candidates.	52	26	22	4
	125	92	28	5

October 21-22, 1952 (The Alcazar, Cathedral and Madison Sts., Baltimore, Md.)

		Passed	Failed	Absent
1st exam. candidates.	413	331	79	3
re-exam. candidates.	39	20	17	2
	452	351	96	5

Our Board has registered by Inter-state Registration in the past year (Jan. 1, 1952, to Dec. 31, 1952) three hundred and forty-six (346) nurses:

- 1 each from the following States: Arkansas, Idaho, Kansas, Montana, New Hampshire, Rhode Island and Utah.
- 2 each from: Georgia, Iowa, Kentucky, Louisiana, Maine, Nebraska, South Dakota, Wis.
- 3 each from: Colorado, Washington State
- 4 each from: Florida, Minnesota, Missouri, Oregon, South Carolina
- 5 each from: Texas and Vermont
- 6 each from: Connecticut, Indiana, Tennessee

7 from: Michigan
 8 from: Delaware
 9 each from: Illinois, New Jersey
 10 from: Ohio
 11 from: California
 13 each from: Massachusetts, West Virginia
 16 from: North Carolina
 17 from: Virginia
 22 from: District of Columbia
 46 from: New York
 73 from: Pennsylvania
 14 from: Canada
 1 from: Philippine Islands

In 1952, 692 students were admitted to schools of nursing in Maryland. On December 31, 1952, there were 1,785 students in the schools.

Total Enrollment (1952) 1,785

Total Enrollment (1951) 1,839

Showing a decrease of— 54

Licensed Practical Nurse Department

The total number of Maryland Practical Nurse Licenses issued to date (Dec. 1922 to December 31, 1952) is 2,814. Original licenses issued in 1952 were

202. Licensed Practical Nurse renewals for the year 1952 were 1,154. Therefore, the total number licensed for 1952 was 1,356.

Three (3) regular examinations for practical nurses and one (1) special examination for re-examination candidates only were held during 1952:

Feb. 2, 1952 (Special Exam. held at Mercy Hospital)

	Passed	Failed	Absent
re-exam. candidates... 12	11	1	0
<i>April 16, 1952 (Osler Hall)</i>			
1st exam. candidates... 95	86	7	2
re-exam. candidate.... 1	1	0	0
—	—	—	—
96	87	7	2

June 25, 1952 (Osler Hall)

1st exam. candidates. .	14	12	0	2
re-exam. candidates. . .	4	2	1	1
	—	—	—	—
	18	14	1	3

October 22, 1952 (The Alcazar)

1st exam. candidates...	96	90	5	1
re-exam. candidates...	1	0	1	0
	—	—	—	—
	97	90	6	1

(Mrs.) ELIZABETH F. NORWOOD, R.N.,
 President

* * * * *

VOLUNTARY PENSION PLANS*

The following is a simplified explanation of the bills which have been introduced to provide tax deferments on amounts paid to purchase retirement annuities. These bills (H.R. 10 and H.R. 11, 83rd Congress) are now pending before the Ways and Means Committee of the House of Representatives.

In December 1952 the House of Delegates of the American Medical Association reaffirmed its position advocating the enactment of legislation of this type.

During the first week of the 83d Congress bills were again introduced to permit tax deferments on amounts used to purchase retirement annuities. These measures, H.R. 10 and H.R. 11, which were introduced by Mr. Jenkins of Ohio and Mr. Keogh of New York, are identical with

the "Keogh-Reed" bills of the 82d Congress. The bills are designed to encourage the establishment of voluntary pension plans by individuals and to provide more equitable tax treatment for self-employed persons. The bills in their present form now include all the amendments suggested by the American Medical Association at hearings on the original legislation last May.

Through amendment of the Federal Internal Revenue Code, the bills would allow physicians and other self-employed individuals to deduct from their taxable income those amounts used each year to finance restricted retirement plans. Employed persons not covered by existing pension plans also would qualify for the tax deduction privilege.

Income received later during the years of retirement, either from pension funds or insurance annuities, would then be taxable under the pre-

* Committee on Legislation of the American Medical Association.

vailing rates. In other words, they provide tax deferment but not tax avoidance.

Physicians, dentists, lawyers, architects, farmers, store owners and the many others who comprise the nation's self-employed have long been neglected in federal tax legislation relating to pensions. The purpose of these bills is to eliminate the discrimination and inequities existing under present tax laws. By extending the tax deferment privilege to the country's ten million self-employed, and also to millions of employees who are not covered by pension plans, this new legislation will give them the incentive to save for old age during their best earning years.

Under Section 165 (a) of the 1942 Revenue Act, millions of employees covered by more than 16,000 approved pension plans are already receiving the benefit of pension tax deferment. They pay no tax during their working years on the employer's contribution to their retirement fund, even though it actually is extra compensation to the employee. After he retires, however, the employee must pay the tax on the part of the retirement benefit which was financed by the employer.

To provide a similar tax arrangement for self-employed persons, the bills would allow annual deductions of 10 per cent of earned net income, or \$7,500, whichever is smaller. Total deductions

during a taxpayer's lifetime could not exceed \$150,000. The funds excluded from taxable income would have to be paid either to a trust fund established by an association for the benefit of its members or to an insurance company as premiums for a retirement annuity contract. In either case, no income payments or cash refunds could be made before the age of 65 except in cases of total disability or death.

The bills include a provision enabling persons already between the ages of 55 and 75 to make larger annual deductions than the basic 10 per cent or \$7,500. This is a practical equivalent to the past service credits allowed in many employee pension plans. The bills also provide for a carry-over of unused deductions for a period up to five years. This is designed to give equitable treatment to persons with extreme fluctuations in income.

This legislation will be of particular benefit to physicians who go through a long and costly period of training and whose peak earnings are bunched into a comparatively short period of years when they are subject to high income tax rates.

This legislation, which has the approval of the American Medical Association and twenty other national organizations, can be enacted by the 83d Congress if physicians and all other self-employed persons work actively together for its passage.

Maryland Academy of General Practice

President—Harold Plummer, M.D., Preston

President-Elect—Lauriston L. Keown, M.D., 1938 Linden Ave., Baltimore

Secretary-Treasurer—Nathan E. Needle, M.D., 4215 Park Heights Ave., Baltimore

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Executive Secretary—Mr. Wm. J. Wiscott, 1818 Ashburton St., Baltimore

POST-GRADUATE STUDY REQUIREMENTS FOR REGULAR AND ASSOCIATE MEMBERS

1. *What are they?*

150 hours over each 3 years, 50 hours of which must be obtained from formal post-graduate studies.

2. *What is meant by "Formal" Post-Graduate Studies?*

A. Courses sponsored and presented as such by medical teaching institutions.

B. Courses sponsored as such by the Maryland or American Academy.

C. Various courses throughout the state may be specifically approved as such by the Board of Directors of the Maryland Academy.

D. Certain courses over the nation may be approved by the American Academy.

E. Courses out of the state approved as such by the Maryland Academy.

F. Annual meeting of the American Academy of General Practice.

G. The annual meeting and Scientific Assembly of the Maryland Academy.

3. *What is included in the 100 hours of Non-Formal Post-Graduate Studies?*

A. Hospital staff meetings and clinicopathologic conferences.

B. County, district or state medical society scientific meetings.

C. A.M.A. or other scientific medical meetings drawing attendance from the nation or a large district.

D. Scientific medical meetings of study clubs or various state groups.

E. Cancer society or Heart association scientific meetings.

F. All other scientific medical meetings.

4. *How is the Time Credit figured?*

On a clock-hour basis unless a definite accredited time has been designated by the approving body. In the latter case, official credit is announced.

5. *How difficult is it for a busy general practitioner to meet these requirements?*

An average of $16\frac{2}{3}$ hours formal study and $33\frac{1}{3}$ hours of non-formal post-graduate studies a year is easily attained.

The annual meeting and Scientific Assembly of the Maryland Academy will give 8 hours formal credit.

The spring meeting and Scientific Assembly and the spring and fall seminars each will give a minimum of 4 hours formal credit.

Attendance at 9 hospital staff meetings of 1 hour each, 9 county or city meetings of 1 hour each or more, depending upon the number of speakers and time allotted to each, and the annual meeting of the Medical and Chirurgical Faculty of Maryland will cover the $33\frac{1}{3}$ hours of non-formal post-graduate study.

CLOSED CIRCUIT TELECAST— UNIVERSITY HOSPITAL

A limited number of members of the Maryland Academy participated in a post-graduate television clinical session held in Gordon Wilson Hall, University Hospital, Thursday, January 15. The program was presented under the auspices of the Post-Graduate Committee of the School of Medicine and in cooperation with the staff of WBAL-TV.

Beginning promptly at 8:50 A.M. with some music,

a brief introduction started the program at 9 o'clock, and except for one hour for lunch, it continued through 36 sequences, ending at 5:00 P.M. It was designed to present to the general practitioner a full day of clinical instruction, including instructions and demonstration of microscope slides, detailed operative instruction from the operating room, and demonstrations of patients in the various clinics. The viewers were able to follow the instructions and demonstrations in a relaxed atmosphere. At times the program was interspersed with music.

The telecast demonstrated the possibilities provided by a closed circuit micro-wave to transmit clinical instruction to remotely situated Maryland physicians from the University. It also showed it was possible to include a return audience circuit directly to the studio, thus enabling the audience to ask questions of the speaker or demonstrator. At one point in the program a 15-minute broadcast from WBAL-TV was transmitted to the hall. This demonstrated the possibility of including in any telecast, programs from more than one source. In fact, the entire program as used, was picked up from a total of four separate studios.

The committee in charge of arrangements included Dr. Howard M. Bubert, Dr. John A. Wagner and Mr. George Buck from the School of Medicine and University Hospital, and Messrs. D. L. Provost, John Wilner, Bob Jones, Lewis Wagner, Raymond Brunner and William C. Bareham from WBAL-TV.

The program was designed to include a diversity of medical subjects. In general, they fell into three main groups: objective clinics, clinico-pathologic science demonstrations and round tables or symposia. A total of 29 members of the teaching staff participated in presenting 14 different medical conditions.

In addition to the limited number of members of the Maryland Academy, members of the county medical societies, city medical societies, faculty heads, President H. Clifton Byrd and several members of the Board of Regents of the University of Maryland were present.

SPRING SCIENTIFIC ASSEMBLY

May 14, 1953

Cardiovascular diseases will be the subject discussed at our Spring Scientific Assembly. Because of the cooperation of the Heart Association of Mary-

land, we are able to participate in an exceptional program. An all-day session on heart diseases will be held in the Administration Building of the National Health Institute, Bethesda, on May 14th, from 9:00 A.M. to 4:30 P.M.

The following tentative program has been arranged by the committee headed by Dr. Nathan E. Needle and Dr. Lauriston L. Keown of the Academy, and Dr. Helen B. Taussig, *President*, and Dr. William S. Love, Jr., *Chairman of the Program Committee*, of the Heart Association.

9:00-10:00—Registration

10:00-10:40—Clinic Patient Demonstration:

Dr. Helen B. Taussig,
Associate Professor Pediatrics, Head of Heart Department, Harriet Lane Home, Johns Hopkins Hospital

Dr. William S. Love,
Associate Professor of Medicine and Head of Cardiology Department, University of Maryland, School of Medicine

Dr. E. Cowles Andrus,
Associate Professor of Medicine, Johns Hopkins Medical School

Morning session—Dr. Harold Plummer, *President, Maryland Academy of General Practice*, presiding

10:40-11:20—Hypertension:

Dr. Caroline Thomas,
Associate in Medicine, Johns Hopkins Medical School

11:20-12:00—Cardiac Emergency:

Dr. Maurice C. Pincoffs,
Professor and Head of the Department of Medicine, University of Maryland, School of Medicine

12:00-12:30—Question Period

12:30- 2:00—Luncheon Recess—(Reservation must be made in advance)

2:00- 2:40—The Clinical Evaluation of Treatment of Occlusive Arterial Diseases:

Dr. Irving S. Wright,
Professor of Clinical Medicine, Cornell University Medical School

2:40- 3:20—Congestive Heart Failure:

Dr. Robert L. Levy,
Professor of Clinical Medicine, College of Physicians and Surgeons, Columbia University

3:20- 4:00—Coronary Thrombosis and Angina Pectoris:

Dr. Paul D. White,
Former Clinical Professor of Medicine, Harvard Medical School

4:00- 4:30—Question period.

This tentative program may be subject to revision. It is hoped that a tour of the National Health Institute may be included. Copies of the complete program will be mailed to you.

The importance of this Spring Assembly, because of its subject and the outstanding authorities who will participate, makes it a "must" for every member of the Academy. Invite your colleagues to attend. This Assembly is not closed session but is open to all physicians in Maryland. The only request is that those who wish luncheons shall notify your secretary or the secretary of the Heart Association of Maryland, 32 East 25th Street, Baltimore 18.

NEW MEMBERS

Since our Annual Meeting the following physicians have been elected into *Active* membership:

G. J. Weems, Huntingtown
Catherine V. Kemp, 1300 Wildwood Pkwy., Baltimore
Richard Anthony Yates, Olney
Nathan R. Thomas, Ocean City
Emily H. Wilson, Lothian
Malcolm Dudley Phillips, Darlington
Max R. English, 5713 Belair Rd., Baltimore

The following have become *Associate* members:

Frank T. Kasik, Jr., Parkville
Frederick P. Sheppard, Queenstown
Irving G. Hoyt, Queenstown
Andrew C. Marshall, Salisbury

Jesse O. Purvis, Annapolis, was elected to *Emeritus* membership.

ELECTION OF MEMBERS

The constitution of the Maryland Academy provides that members of the Medical and Chirurgical Society of the State of Maryland shall be eligible for

membership. Application for membership shall be made in writing. Election to membership shall be by the majority of the Board of Directors.

MEMBERSHIP COMMITTEE FOR 1953

Chairman—Merrill Cross, 8248 Georgia Ave.,
Silver Spring

Henry L. Fahrney, Frederick
James Frenkil, 1422 Park Ave., Baltimore
B. L. Grant, Shadyside
Rodney Layton, Centreville
Martin Buell, Easton
Hugh Ward, Owings
B. B. Kneisley, Hagerstown
Norman Sartorius, Pocomoke City
George Burgdorf, Ellicott City
Martin Rothstein, Frostburg
Allen Maulton, Westminster
Eldridge Wolff, Cambridge
Roy Guyther, Mechanicville
William Gray, Salisbury
Sarah Peyton, Crisfield
William Brainin, Capitol Heights

MARYLAND AND D. C. MEETING

A joint meeting of the Maryland and District of Columbia Academies will be held on April 23rd. Plans for the program are now being worked out by Dr. Merrill Cross and a committee from the District Academy. This meeting promises to be an important one. Complete details will be mailed later.

* * * * *

THE ROLE OF THE BALTIMORE CITY MEDICAL SOCIETY IN THE REORGANIZATION AND APPROVAL OF DOCTORS HOSPITAL

WILLIAM SCHUMAN, M.D.

The Board of Trustees of Doctors Hospital and the Executive Committee of the Baltimore City Medical Society have announced the approval of the hospital by the Council on Medical Education and Hospitals of the American Medical Association on December 1, 1952.

The accreditation of the hospital is the result of a

plan of reorganization which began in 1949, two years after the erection of the hospital on its North Charles Street site by a small group of local physicians. Control of the new institution was transferred from its founders to a Board of Trustees composed of laymen with no financial interest in the hospital.

In November 1949, the writer requested the per-

mission of the Board of Trustees to arrange for a professional survey of the hospital, with particular emphasis on surgery. This authority was given, and the initial step was the enlisting of the voluntary services of Dr. Ross Z. Pierpont to direct such a survey. Dr. Pierpont obtained the assistance of Doctors Donald B. Hebb, Harry C. Hull, and George A. Stewart. Dr. Pierpont's group conducted a thorough investigation of the surgical activities of the hospital, and then received permission of the Board of Trustees to turn their function over to the Baltimore City Medical Society. Dr. John M. T. Finney, Jr., President of the Medical Society at that time, appointed a committee headed by Dr. Edward S. Stafford to continue the survey and broaden its scope, so as to include all aspects of the hospital organization. The committee included representatives of the various specialties as well as Dr. Edwin L. Crosby, then Medical Director of the Johns Hopkins Hospital. At the conclusion of the official survey by the Medical Society, the recommendations made by Dr. Stafford's committee were submitted to the hospital trustees, who agreed to put into effect the plan of reorganization of both the administrative and medical staffs. The first measure taken was the appointment of Mr. David B. Snyder as Administrator in May 1951. Another recommendation carried out was the creation of a Medical Advisory Board composed of recognized surgeons, specialists, and other physicians to direct the medical policies of the hospital. Dr. Henry J. Wollenweber served as the first chairman of this board, and was succeeded in March 1952 by the writer. At the same time the trustees appointed one of its members, Mr. Max Sokol, a member of the Baltimore bar, chairman of a committee to negotiate with the Baltimore City Medical Society in an effort toward early approval of the hospital by the A.M.A. A joint group of the trustees and the medical board of the hospital held a series of meetings with the officers and Executive Committee of the Medical Society, with Dr. Samuel McLanahan, Jr. presiding. In October 1952, the Medical Society put its approval on the measures taken by the trustees to reorganize the hospital, and forwarded to the American Medical Association its recommendation that Doctors Hospital be approved. Early in December, official notification from the Chicago headquarters of the A.M.A. was received by the hospital.

The Medical Advisory Board is made up as follows:

William Schuman, *Chairman*

Surgery—Ross Z. Pierpont
 Edgar F. Berman
 Donald B. Hebb
 Benjamin Sarubin (chief)

Medicine—A. A. Sussman (chief)
 Stephen J. Van Lill 3rd

Pediatrics—C. Loring Joslin
 Neuropsychiatry—Leon Freedom

Pathology—Henry J. Wollenweber (Pathologist)

Obstetrics and Gynecology
 Christian F. Richter
 Earle M. Wilder
 William Schuman (chief)

Orthopedics—I. H. Maseritz
 Milton J. Wilder

Urology—Charles Levy
 Ear, Nose, & Throat—Jerome Snyder
 X-ray—Eugene L. Flippen (Radiologist)

In addition to the Medical Advisory Board, there is an Executive Committee, which is the working committee of the staff,—including such functions as credentials, records, house staff, clinical conferences, tissue review, etc. This committee is composed of the department chiefs and an equal number of general practitioners. Decisions of the Executive Committee are subject to the approval of the Medical Advisory Board. The original visiting staff of 50 doctors has increased to 125 general practitioners and specialists. The hospital has a qualified Resident and two internes. A unique feature of the hospital is a formally organized Institute of Postgraduate Medical Studies for general practitioners, the courses of which are approved for credit by the Maryland Chapter of the American Academy of General Practice.

Doctors Hospital is a member of the American Hospital Association and is affiliated with the Maryland Hospital Service (Blue Cross). It has 85 beds, of which 18 are obstetrical and 15 pediatric, the remainder being for acute medical and surgical cases. The hospital has a ward service for obstetrical patients, and conducts a pre-natal clinic. Plans for future expansion include two additional floors to double its present capacity, an accident and outpatient department, and improved facilities in all existing services.

The role taken by the Medical Society in assuming the function of an investigator for the A.M.A. is probably unprecedented locally. That it performed

this function with great efficiency and guided by the best traditions of the Society is acknowledged by all concerned. It will be of future interest whether this will remain an isolated experience for the medical Society or that other instances will arise in which the Society will be called upon to act as an investigating and recommending body in the organization of a local hospital. The fact remains that in the case of Doctors Hospital the result was most salutary for the hospital, the medical profession, and the entire community.

The writer, on behalf of the Board of Trustees and the Medical Advisory Board of the hospital, desires to take this opportunity to express their appreciation and admiration for the constructive efforts made by the original voluntary survey group and by the various officers and survey committee

members of the Medical Society to bring Doctors Hospital to its present state of organization. Particularly noteworthy has been the splendid spirit of cooperation shown by Dr. McLanahan, recent President, and Dr. Wetherbee Fort, present President of the Society. Acknowledgment is also made to Dr. George H. Yeager, Editor, for space in this Journal to tell the story of the reorganization and approval of the hospital.

With the Medical Society promising to maintain a continued interest in the progress of Doctors Hospital, it is the determination of the hospital trustees, medical board, and staff to pursue every means for the further improvement of the hospital, so that general practitioners and specialists of every segment of the local profession will proudly associate themselves with Baltimore's youngest hospital.

FAMILY SPENDING FOR MEDICAL CARE

THE AMA WASHINGTON LETTER NO. 9, FEBRUARY 27, 1953

Government statisticians estimate that the average urban family spent 4.7% of all its expenditures on *medical care* in 1952. The Bureau of Labor Statistics, which computes the monthly cost of living index, has divided total family spending as follows: 30.1% for food, 32.0 for housing, 9.7 for clothing, 11.0 for transportation, 4.7 for medical care (including health insurance costs), 2.1 for personal care, 5.5 for reading material and television and 5.0 for other goods and services. In arriving at price changes in family spending each month, BLS will take into account price fluctuations in each category listed above. The revised index is the outgrowth of a study that started in 1950.

Woman's Auxiliary to the Medical and Chirurgical Faculty

MRS. GEORGE H. YEAGER, *Auxiliary Editor*

REVIVING AN OLD TRADITION

Records at the Medical and Chirurgical Faculty Building bear evidence that "in the good old days" early in 1900 there were many parties and various entertainments to which the doctors brought their wives. Therefore, the Auxiliary feels that this year in sponsoring The Medical and Chirurgical Ball on the Monday night that the Annual Meeting opens, by holding the Joint Faculty-Auxiliary Luncheon, on Wednesday, to hear Dr. Bauer, President of the A.M.A. speak, and by again putting on the annual Creative Arts Show, we are actually only reviving or renewing that old "College" spirit!

The Faculty Ball is not really a new idea either, but is a good one, a way to get us all to town in plenty of time for the Annual Meeting. It will provide us with a chance for a state wide reunion in a relaxed atmosphere and in pleasant surroundings. It gives Baltimore City, at last, an opportunity to at least start to return in kind some of the gracious hospitality always extended by the Counties at the Semiannual.

Be sure to make *hotel reservations* early for Monday night, April 27th. Pack that black tie or dark suit, and gay gown and meet us at "The Alcazar" for *An Evening In Paris!*

Mrs. E. Ellsworth Cook is General Chairman of The Medical and Chirurgical Faculty Ball; Mrs. Ross C. Brooks is Chairman on Arrangements; Mrs. Irving Taylor, Folies "Bare" Gère; Mrs. Richard Garrett, Tickets; Mrs. Arthur T. Ward, Jr., Co-Chairman, Tickets; Mrs. John DeHoff, Program; Mrs. J. Arthur York; Patron List; Co-Chairmen on Patrons are Mrs. Homer Todd and Mrs. Everett S. Diggs; Mrs. Edwin Stewart, Public Relations and Mrs. Newland E. Day, Reservations; Mrs. Norman Freeman is Co-Chairman on Reservations. Mrs. Raymond Markley has Decorations; Mrs. Harold Vyner, Recruitment Dolls; Mrs. Thomas C. Webster, Novelties; Mrs. Philip Lerner, candy; Mrs. W. Kennedy Waller, Perfume from Helen Dugan Boyce, Inc.; Mrs. Daniel Pessagno, Flower Girls; Mrs.

James Russo, Co-Chairman, Flower Girls; Mrs. Joseph C. Sheehan, French Fashions; Mrs. Robert Goldstein, Singing Star; Dr. Louis Kolodner, Master of Ceremonies; Mrs. John R. Davis, Mrs. Hyman Schiff, and Mrs. Jack Rosin, Telephone Chairmen; and Mrs. J. C. Wich and Mrs. Herbert Wilgis, Publicity.

Mrs. Beverley C. Compton is Chairman of the Creative Arts Show; her Co-Chairmen are Mrs. Frank R. Smith, Jr., and Mrs. Everett S. Diggs. Art Chairmen are Mrs. John Parsons and Mrs. A. Murray Fisher. Other Committee members are: Mrs. I. Ridgeway Trimble, II, Mrs. Benjamin Rutledge, Mrs. Marius P. Johnson, Mrs. Howard C. Smith and Mrs. Thomas Chambers. County representatives are: Mrs. Louis Z. Dalmau, Mrs. A. Talbot Brice, Mrs. P. S. Lansdale, Mrs. J. M. Bankhead, Mrs. David S. Clayman and Mrs. S. R. Wells.

AMERICAN MEDICAL EDUCATION FOUNDATION

One of the A.M.A.'s goals for 1953 is to *explain* as well as to actually extend Medical Education and the doctor supply to the public. "Today's Health" has been listed as one of the media to be used in this educational project, and a great effort is under way to make this only factual, authentic, health magazine also the most attractive and appealing one on the market. Another medium to be used in connection with the A.M.E.F. educational appeal is the film "Your Doctor" 16 m.m. available free from A.M.A. film library, 535 North Dearborn Street, Chicago 10, Illinois. If your own local Auxiliary has not yet joined in support of the A.M.E.F. please remember the plea of our National Auxiliary Committee on the subject, which is "Every Auxiliary a Contributor!" After all, under an Administration that is declared to be friendly to *every* kind of American effort, responsibility, and initiative, we have a chance to show that private sources can and will come to the aid of our Medical Schools without government interference.

KNOW THE ANSWERS!

As a doctor's wife you will be better informed if you've read two new pamphlets available free from the A.M.A., P. R. Department, 535 North Dearborn Street, Chicago 10, Illinois. They are: "I. L. O. Spells Danger" (International Health Organization) and "How To Pay Your Medical Bill." In addition, there is a small inexpensive book that will make you think, called "Remember These Things" by Paul Harvey and available from The Heritage Foundation, 75 East Wacker Drive, Chicago 1, Illinois.

TABLES RESERVED FREE

While they last, tables may be reserved, without charge, for the Medical and Chirurgical Faculty Ball, to be held on Monday night, April 27th, at "The Alcazar" in Baltimore, as part of the Annual Meeting Program. Members of the Faculty or the Auxiliary may engage a table for ten simply by writing or telephoning Mrs. Newland E. Day, 3424 Guilford Terrace, Baltimore 18, Maryland. Telephone—HOPkins 2977.

VOLUNTEER YOURSELF!

General Williams, Medical Director of Civil

Defense, who recently spoke to the Woman's Auxiliary to the Baltimore City Medical Society, mentioned the need for women who will take the Nurse Assistant, Nurse's Aide or First Aid courses, and the need for each neighborhood or city block to organize a baby-sitting center so that active mothers may be released to man Casualty Clearing Stations or to assist Hospital or other Civil Defense posts. However, General Williams cautioned that "the best way to get out volunteers is to *first* volunteer yourself! Americans like to lead, but resent being pushed."

SAFETY CAMPAIGN MOVIE

Our Maryland Auxiliary has been particularly concerned over the automobile accident toll. Most accident prevention weeks, home, school, rural, etc., are sponsored on a local level. There is usually a local Safety Council which will welcome any Auxiliary support. If you want to use a very clever animated cartoon to enliven a "safety" program there is one called "Once Upon a Time" available from the Metropolitan Life Insurance Company, 1 Madison Avenue, New York 10. This may also be used on Television.

**ARMED FORCES TO REDUCE CALL ON DOCTORS,
PRESIDENT ANNOUNCES****THE AMA WASHINGTON LETTER NO. 9, FEBRUARY 27, 1953**

After first planning to call up 1,800 physicians for April, May and June, the military services have decided they can get along with 1,200. Announcement of the lowered quota was made by President Eisenhower, who credited the reduction to recommendations of the Rusk Committee. The 1,200 to be taken in the next quarter compare with 1,552 called up in January, February and March.

Meanwhile, Defense Department's bill for extending the doctor draft act, made public two weeks ago, still has not been introduced on Capitol Hill. It is known that Office of Defense Mobilization and the Budget Bureau are giving it careful study. Also, there are reports that White House advisers are hopeful that more reforms can be written into the bill.

MEDICAL SECTION
of the
BALTIMORE CITY MEDICAL SOCIETY
1211 Cathedral Street

Tuesday, May 12, 1953, 8:00 p.m.

Election of Officers.

Important message.

This will be a brief meeting. This is the first time this Section has held a meeting and all the members are urged to attend.

SYMPOSIUM ON USE AND ABUSE OF DRUGS AND COSMETICS

Osler Hall, 1211 Cathedral Street, Baltimore

Friday, May 15, 1953, 8:00 p.m.

Participants:

Dr. Kenneth C. Blanchard, The Johns Hopkins Hospital, *Moderator*

Dr. Milton S. Sacks, University Hospital

Dr. Leslie N. Gay, Baltimore

Mr. Paul C. Wolman, Jr., Assistant United States Attorney, Baltimore

The Symposium is under the auspices of the Joint Committee on Medicolegal Problems of the Baltimore City and Maryland Bar Associations and the Medical and Chirurgical Faculty. The program is being arranged by the Symposia Management Subcommittee which is composed of the following members: Mr. S. C. Berenholtz, Mr. W. L. Galvin, Mr. A. Sodaro, Mr. T. C. Waters, Dr. R. S. Fisher, Dr. L. Krause, Dr. R. C. Tilghman, and Dr. I. R. Trimble.

All the members of the Medical and Chirurgical Faculty are cordially invited to attend this meeting.

ANESTHESIOLOGY SECTION
of the
BALTIMORE CITY MEDICAL SOCIETY
1211 Cathedral Street

Edward I. Lederman, M.D., *Chairman* Leah R. Camp, M.D., *Secretary-Treasurer*

Wednesday, May 20, 1953, 8:30 p.m.

Contributions of an Anesthesia Study Commission. Henry S. Ruth, M.D., Professor of Anesthesiology, Hahnemann Medical College and Hospital, Philadelphia, Pennsylvania.